PARAMOUNT
PHYSICAL THERAPY

Registration and Insurance Information

Patient Information

Name:_____ Date: _____

I prefer to be called:_____

Address:_____City:_____State:_____

Zip Code:_____ Telephone:(____)_____Mobile Telephone:(____)_____

Email _____Check Appropriate Box: ☐Minor ☐Single ☐Married

Date of Birth:_____ Social Security Number:_____

In case of emergency contact: _____Telephone: _____

Employer:_____ Work Telephone:_____

Whom may we thank for referring you?

_____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

Address:_____City:_____ State:_____

Zip Code:_____ Telephone: (___)_____ Mobile Telephone: (____)_____

Insurance Information

Name of Insured_____Relationship to Patient:_____

Date of Birth:_____ Social Security Number: _____

Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____

City:_____ State:_____ Zip Code: _____

Insurance Company:_____

Address of Insurance Company: _____

City: _____State:_____Zip Code:_____

Telephone Number of Insurance Company: _____

Identification Number: _____ Group Number:_____

Do you have any additional insurance? ☐ No ☐ Yes IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____Relationship to Patient:_____

Date of Birth:_____ Social Security Number: _____

Insurance Company:_____

Address of Insurance Company: _____

City: _____State:_____Zip Code:_____

Telephone Number of Insurance Company: _____

Identification Number: _____ Group Number:_____

☐ Please check if you choose to select self-pay option of $120/visit

_____ _____

Signature Date