

## PATIENT REGISTRATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle I. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Doctor \_\_\_\_\_ Doctor Phone # \_\_\_\_\_  
Chief complaint/Diagnosis \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_  
In case of emergency, Please contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # of contact person \_\_\_\_\_

### Responsible Party if different from Patient:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Employer \_\_\_\_\_

### Insurance Information:

(This office offers the courtesy of Insurance Billing, however, we do not have a contract with all companies.)

Is this an on the Job Injury? \_\_\_\_\_ Claim# \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Claim Manager \_\_\_\_\_ Phone # \_\_\_\_\_

Is this a Motor Vehicle Accident? \_\_\_\_\_ Claim # \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Claim Manager \_\_\_\_\_  
Phone # \_\_\_\_\_ Address \_\_\_\_\_

Private Insurance \_\_\_\_\_  
Billing Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Identification # \_\_\_\_\_ Group# \_\_\_\_\_

I the undersigned certify that I or my dependent have insurance coverage with the above listed insurance and assign directly to Kay Lakey Physical Therapy/Kay Lakey RPT, all insurance benefits. I understand that I am financially responsible for all deductibles, non-covered services, or non-authorized services. I also authorize Kay Lakey Physical Therapy to release medical and billing information to my physician or insurance company if requested.

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Signature of Insured/Guardian

Date