Family Physical Therapy

7 PARK AVENUE
COLCHESTER, CT 06415
P (860) 531-3222 **F** (860) 531-3224

3 WEYMOUTH RD
ENFIELD, CT 06082
P (860) 698-6308 **F** (860) 698-9658

PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____WORK: _____ CELL: _____

SS#: _____ GENDER: _____ DOB: _____

EMAIL ADDRESS FOR APPOINTMENT REMINDERS: _____
(CHECK BOX IF YOU WOULD LIKE TO RECEIVE HEALTH & WELLNESS LITERATURE AND NEWSLETTERS FROM FAMILY PHYSICAL THERAPY) ☐

REFERRING PHYSICIAN: _____

EMPLOYER: _____ PHONE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE

NAME: _____

MEMBER ID #: _____

POLICY GROUP #: _____

EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

SECONDARY INSURANCE INFORMATION

NAME: _____

MEMBER ID #: _____

POLICY GROUP #: _____

EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

IS THIS VISIT RELATED TO WORKER'S COMPENSATION INJURY OR AN AUTO ACCIDENT INJURY? YES OR NO

ASSIGNMENT OF BENEFITS AND RELEASE (INITIALS)

I understand I am responsible for co-payments and any services not covered by my health plan at time of service. _____

I authorize Family Physical Therapy to release any medical information required in order for claim processing. _____

I hereby authorize my insurance benefits to be paid directly to Family Physical Therapy. _____

SIGNATURE: _____ DATE: _____