Camas Physical Therapy
REGISTRATION FORM

(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address / P.O. Box	Social Security no.:	Home phone : ( )

Cell Phone:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑Internet

❑ Motor Vehicle Accident ❑ Workmen's Comp ❑ No Insurance

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Company:	Address:	Insurance Phone: ( )

Policy Number:	Group Number:	

Employer:	Employer phone no.: ( )

Are you covered by more than one insurance company? ❑ Yes ❑ No					
Please indicate primary insurance	❑ MVA	❑ Work Comp	❑ Medicare	❑ Cash	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone no.: ( )	2nd Phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Camas Physical Therapy or insurance company to release any information required to process my claims. If balance becomes delinquent, I agree to pay all collection costs. Accounts over 60 days may be subject to a monthly finance charge of 12% per year of the unpaid balance, UNLESS financial arrangements have been made prior. A $50 bank fee will be charged for NSF checks.

Patient/Guardian signature *Date*