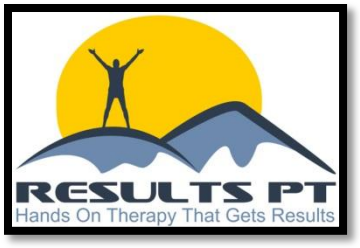

Patient Registration Information

First Name: _____MI_____ Last Name_____

Address: _____Apt. #:_____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening: _____ Cell: _____

Patient Email Address: _____ Date of Birth: _____ Age _____

Sex: Male ____ Female ____ Marital Status: Married ___Single___ Divorced___ Widow___

Family Physician: _____Address: _____Phone: _____

Orthopedic Physician: _____ Address:_____ Phone _____

Emergency Contact

Name: _____ Relationship _____
Address: _____ Phone: _____

IS THIS A TRAUMA OR INJURY RELATED TO:
Work: Yes ____ No ___ ; Auto Accident: Yes ___ No ___ ; Other: Yes ___ No ___
Date of Injury _____ Is there an Attorney or Litigation Involved? Yes ___ No ___
Attorney Name _____ Address _____
Phone _____ Email _____

Payment is Due on the Date you receive Physical Therapy Service

I understand that medical insurance is an agreement made between me and my insurance company. Results PT does not bill your insurance. We will provide you with a paid invoice for services rendered that you may submit to your insurance carrier for reimbursement. Payment can be made in cash or personal check at the time of service.