ADVANTAGE
Therapy Centers

Patient Registration

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)** All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_________	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Residence address City State Zip	Home Phone:	Patient's SS #

Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's SS #

E-mail address

Name of employer Address	Business Phone	Occupation

Name of Spouse/Parent	Spouse/Parent Birthdate ____/____/_____	Spouse/Parent SS #	Business phone

Reason for Visit:	Referred by: (include address and phone)

Person to contact in case of emergency:	Relationship to patient	Phone

Medicare Yes [ ] No [ ]	Medicare #	Medicaid Yes [ ] No [ ]	Medicaid #	Effective Date

Medicare Secondary insurance name Address	Policy #	Group #

Workers' Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] **If Yes-put W/C or MVA carrier below**	Date of Accident	Claim #	Case Worker's Name	W/C or MVA Insurance Phone #

Primary insurance company Address	Insurance Phone #

Subscriber Name	Subscriber birth date	Policy #	Group #

Secondary insurance name Address	Policy #	Group #

Medicare Lifetime Signature on File:
I request that payment of authorized Medicare benefits be made on my behalf to Advantage Therapy Centers for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

____ ________________________
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned authorize payment of medical benefits to Advantage Therapy Centers for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ ________________________
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

HOW DID YOU HEAR ABOUT US?

PHYSICIAN___ FAMILY/FRIEND___ NEWSPAPER AD___ YELLOW PAGES___ OTHER___