BestLife Physical Therapy AND SPORTS MEDICINE

PATIENT REGISTRATION

A.Patient Information			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Email:	DOB:	SSN:	
Home Phone:	Cell Phone:	Work Phone:	
Physician Name:	Date of Last Appt:	Phone Number:	
Are you a Student? ❒ YES ❒ NO: If YES, what school do you attend?		Grade Level:	
Please share how you were referred to Best Life?			

B. Emergency Contact Information		
First Name:	Middle Initial:	Last Name:
Relation to Patient: ❒ Spouse ❒ Parent ❒ Friend ❒ Other:		Phone Number:

C. Parent/Guardian Information (only fill out if patient is a minor)			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Relation to Patient:	DOB:	SSN:	
Home Phone:	Cell Phone:	Work Phone:	

D. Employer Information			
Name of Employer:		Occupation:	
Address:	City:	State:	ZIP:

E. Insurance Information: Will we be billing insurance? ❒ YES (please provide Insurance Card) ❒ NO			
Name of Primary Insurance Carrier:	Policy #:	Group #:	
Subscriber (Insured) Information: **Check Here** ❒ if Name, Address, Employer, DOB, and SSN, are same as patient			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Employer:	DOB:	SSN:	
Name of Secondary Insurance Carrier:	Policy #:	Group#	
Subscriber (Insured) Information: **Check Here** ❒ if Name, Address, Employer, DOB, and SSN, are same as patient			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	ZIP:
Employer:	DOB:	SSN:	