

TheraPro REGISTRATION FORM

Please hand insurance card and ID to receptionist and Please print

Today's Date:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address/ P.O Box:			Social Security no.:		Home phone no.: ()		
City:		State:	Zip:		Cell no: ()		
Occupation:		Employer:			Employer phone no.: ()		
How did you find us? (Please check one)		<input type="checkbox"/> MD	<input type="checkbox"/> Internet		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Work	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pgs	<input type="checkbox"/> Other			
Referring MD (Name and phone #):							

INSURANCE INFORMATION

Person responsible for bill:		Birth date:	Address (if different from above):		Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance: <input type="checkbox"/>							
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Workman's Compensation Claim <input type="checkbox"/>		Date of Injury :			Claim #:		
Name of Insurance Company:				Adjustor (Name/Phone #):			

IN CASE OF EMERGENCY

Name of local friend or relative :		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I hereby assign all medical benefits for which I am entitled to TheraPro in the event they file insurance claims on my behalf. I understand that I am responsible for all charges whether paid or not by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount and understand a 30 % addition to defaulted amount will be charged to cover collection fees. Interest may be charged in the amount of 1% per month (12% annually) for unpaid balances over 60 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be as considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of TheraPro as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except in acts of negligence.

Patient/Guardian signature:

Date: