Registration for Services at Gateway Physical Therapy

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 Last Name:	First Name:		MI:
Address:	City:	State:	Zip Code:
Patient's Social Security #:	Home Phone:	Cell Phone:	Birthdate:
May we send you information via e-mail? Yes_____ No_____ E-Mail_____		Sex: M F	Marital Status: M S W D
What type of condition/ injury are you being seen for:	Name of Referring Physician:		
Date of Injury/ First Symptoms:	Employment Related? **Y N**	Auto Accident? **Y N**	Other?
Have you had any therapy/chiropractic this calendar year? **Y N**	If so, how many visits?	Was the therapy performed at your home? **Y N**	
Name of Employer: City & State:		Work Phone: Ext:	
Person to contact in case of emergency:		Phone #:	
Primary Insurance Company:		Is the insurance in your name? **Y N**	
Secondary Insurance Company:		Is the insurance in your name? **Y N**	
Name of Insured, if not Self:	Relationship to Insured:	Insured Social Security #:	
Birthdate of Insured:	Insured Employer Name:		

Please ***INITIAL*** in applicable spaces below.

_____ I received a copy of the Patient Rights and Responsibilities

_____ I received a copy of the procedure for filing a grievance

_____ I give you permission to leave a message on my answering machine regarding medical related issues

Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Gateway Physical Therapy for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. 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 Signature Date

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