MOTIONMATTERS PHYSICAL THERAPY

Client Registration Form

P: 559.876.1191 F: 559.876.9911 www.motionmatterspt.com

PATIENT INFORMATION				
Patient's Last Name	First	Middle	How would you like to be addressed?	
Mailing Address	City	State	Zip Code	
Home Phone	Cell Phone		Work Phone	
Primary Care MD	Date of Birth		Age	Sex
Referring Physicians Name	Social Security Number		Email Address:	
Emergency Contact name	Emergency Contact Phone			
How did you hear about us? ☐ You are a former Patient ☐ Family/Friend ☐ Website ☐ Yellow Pages ☐Building Sign ☐ Insurance Plan ☐ Physician ☐ Other_____				

INSURANCE/FINANCIAL RESPONSIBILITY		
Primary Medical Insurance	ID#	Group #
Policy Holder/Subscriber Name	Policy Holder Employer:	Policy Holder Date of Birth:
Policy Holder Social Security	Relationship to Patient	
Secondary Medical Insurance	ID#	Group #
Policy Holder/Subscriber Name	Policy Holder Employer	Policy Holder Date of Birth
Policy Holder Social Security	Relationship to Patient	
If you are here resulting from: ☐Auto Accident ☐Workplace Injury		**Date of Injury: ___ / ___ / ____**
Insurance / Payor:	Claim #:	Adjuster Name:
Employer/School:	Address	Occupation:
Attorney Name:	Phone #:	

The information above is true and correct to the best of my knowledge. I authorized my insurance company to make payment directly to Motion Matters Physical Therapy. I understand that I am responsible for all charges incurred in this office. I further authorize Motion Matters Physical Therapy to release any and all information concerning my care to my insurance company and my referring physician(s).

_____ _____

Patient or Guardian Signature Date (mm/dd/yy)