ADVANCED PHYSICAL THERAPY CENTER

Patient Express Registration

Date ______________________ ___ Male ___ Female Date of Birth__________________________

___ Single
____ Widow (er)
____ Married

____ _______
Last Name/First Name/Middle Initial Age

____
Street Address (include mailing address if different) City State Zip

____
Home Phone Cell Phone Email Address (important)

____
Emergency contact Phone # Spouse's name (if different than emergency contact)

____
Occupation Employer Name Phone #

My condition is related to: ___ work injury ___ auto accident (State_______) ____ Other_________________________

Date of Injury_______________________________

REFERRAL INFO

____
How did you hear about us?

If by a friend or family member, please give us their address so we may send them a thank you note and small gift.

____
____
____

____
Referring Physician

____
Address City State/Zip

Do you have a follow up appointment? If so when?

Date ____

PAYMENT INFO

____ I have insurance and will assign my benefits to you by completing the "Assignment of Benefits Form". The following information is required prior to first visit.

My coinsurance/copay is $___________

My deductible is $_______________

I am interested in a payment plan. Fees may apply.
____ Yes ____ No

I will be paying my copay at each visit. We accept cash, check, and credit card (Mastercard and Visa).

____ Yes ____ No