Desert Sun Physical Therapy Registration Form

Date:_____

Personal Information

Last Name _____ First Name _____ Age _____ o Male o Female o Single o Married

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Mobile Phone # _____ Email Address _____

Occupation _____ Employer Phone # _____ Employer Name _____

Emergency Contact Name & Phone # _____ Parent/Guardian Name (If Patient is a Minor) _____

My condition is related to: o Work o Motor Vehicle Accident o Sports o Other:_____

Date of Birth _____ Social Security # (Medicare / Tricare Only) _____

Work Status o Employed o Unemployed o Disabled o Retired o Student

Referral Information

How did you hear about us? _____

Primary Physician's Name _____

Referring Physician's Name (if different from above) _____

Physician's Phone #:_____

Do you have a follow-up with your physician?

o Yes o No

If yes, when?_____

Payment Information

- I have insurance (complete copay or deductible info):
  - o My copay is:
  - $_____ per visit
  - o My deductible is:
  - $_____ per year & I have met: $_____
  - * After the deductible is met, my co-insurance is:
  - _____% per visit
- I don't have insurance, and I:
  - o Will pay at the time of service: $_____
  - o Would like a payment plan (Fees may apply)

Credit Card Information (Optional)

__Visa __MasterCard __Discover Card# _____

Name on the card_____ Expiration ____/____ CVV Code _____

o I certify the above information is true to the best of my knowledge. Signed _____