Norfolk Physical Therapy Center
Patient Registration Form

Patient Information

Name_____SS#_____
Address_____
(**if you receive mail at a PO Box please also provide your complete physical address**)
City_____State_____Zip_____
Date of Birth_____Age_____
Home Telephone ( )_____Work Telephone ( )_____
Cell phone ( ) _____
Email address_____
Patient sex ( ) Male ( )Female Marital Status_____
Date of injury/onset_____Job Related?_____Auto Related?_____
Referring Physician_____ Next Appointment with Him/Her_____
Address where you normally see Physician_____
Rehabilitation Nurse (if any)_____
Attorney (if any) _____ phone ( ) _____

Employment Information

Employer Name_____
Address_____
City_____State_____Zip_____
Telephone ( ) _____Occupation_____

Primary Health Insurance_____ (copy of card)
Secondary Health Insurance_____ (copy of card)

Next of Kin
Name_____
Address_____
City, State & Zip_____
Telephone Number_____
Relationship_____

Emergency Notification (Not living with you)
Name_____
Address_____
City, State & Zip_____
Telephone Number_____
Relationship_____

Consent to Treat/Authorization & Assignment of Benefits

I consent to treatment for physical and/or aquatic therapy as ordered by my physician. I authorize and request payment of medical benefits directly to Norfolk Physical Therapy Center. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am responsible for any unpaid balance or any services which are not covered by my insurance. In the event that my account is referred to an attorney or collection agency for collection, I agree to pay all reasonable costs of collection, including an attorney's fee and/or collection agency fees.

_____Date_____
Signed (Patient or Representative)

How did you hear about our services?

☐ **Phone Book** ☐ **Employer** ☐ **Friend** ☐ **Doctor** ☐ **Insurance Company**

_____**Date**_____
NPTC Representative