



DIAMOND PHYSICAL THERAPY

REGISTRATION FORM

PATIENT INFORMATION				E-MAIL ADDRESS: _____			
First Name:		Last Name:		Middle Initial:		Date:	
Address:			City:		State:	Zip:	
Birth date:	Age:	Male	Female	Social Security # :			
Home Phone:		Cell Phone:		Work Phone:			
Chose Diamond because: Insurance Plan				Friend / Family	Website	Former Patient: _____	
Close to work/home		Yellow Pages	MD Referral: _____		Other: _____		
WORK INFORMATION							
Employer:			Work Phone:		Extension:		
Occupation:			Employment Status: Full Time Part Time Retired Not Employed				
CARE PROVIDER INFORMATION							
Referring Dr.:			Referring Dr. Phone:				
Family Dr.:			Family Dr. Phone:				
INSURANCE INFORMATION (Please give your insurance card to the receptionist)							
Primary Insurance Name:							
Subscriber's Name:				Birth date:			
ID # :				Group / Policy # :			
Patient's Relationship to Subscriber: Self Spouse Child Other:							
Name of Secondary Insurance:							
Subscriber's Name:				Birth date:			
ID # :				Group / Policy # :			
Patient's Relationship to Subscriber: Self Spouse Child Other:							
AUTO OR WORK INJURY CLAIM (Please provide your insurance information for backup)							
Insurance Name: Auto:				Labor & Industries:			
Adjuster / Claim Manager:			Phone:		Ext.:		
Address:			City:		State:	Zip:	
Claim # :				Date of Injury:			
ATTORNEY INFORMATION							
Name:			Law Firm:		Phone:		
Address:			City:		State:	Zip:	
IN CASE OF EMERGENCY							
Name:			Relationship to Patient:				
Home Phone:			Cell Phone:				
I authorize my insurance benefits to be paid directly to Diamond Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Diamond Physical Therapy to release any information required to process my claims.							
PATIENT /GUARDIAN SIGNATURE:						Date:	