PATIENT REGISTRATION FORM

Patient Information:

Last Name First Initial			Date of Birth	Age
Address			Marital Status	Gender
City	State	Zip	Home Phone	
Work Phone	Cell Phone		Email Address	
How did you hear about us: ☐ Doctor ☐ Worker's Comp ☐ Friend/Family Reference		Social Security Number		

Responsible Party Information:

Person Responsible for Bill	Relationship
Social Security Number	Date of Birth

Insurance Information: [ ] Individual [ ] WC [ ] Auto [ ] Medicare

Medicare Patients: Are you receiving ANY home health care? ☐ Yes ☐ No

Primary Insurance	ID Number	Group Number
Policy Holder Name		
Billing Address		
Secondary Insurance	ID Number	Group Number
Policy Holder Name		
Billing Address		
Relationship of Insured to Patient	Self-Pay [ ] Yes, Patient Informed of Fees	

Referring Information:

Diagnosis	Date of Injury	Area of Injury
Referring Physician	Phone Number	Fax Number
Family Physician	Phone Number	Fax Number

Emergency Information:

Contact	Relationship	Phone

I hereby assign, transfer, and set over to TriPT all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of medical information needed to determine these benefits. The authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature_____Date:_____