Amelia Physical Therapy Registration Form for Minors

Patient Name_____
Last First Middle initial Nickname
Street Address_____

City_____State_____Zip_____

Phone (H)_____ Date of Birth_____ Age_____ Male/Female

Insurance Plan _____How did you find out about this Practice _____

Policy Holder's Name_____ Date of Birth _____

Address of Policy Holder _____

Referring Physician _____

Email Reminder: Yes or No **Or** Text Reminder: Yes or No (Please provide carrier)

Email Address_____ Cell Phone _____Carrier _____
Emergency Contact:
Name_____Relationship_____

Phone(H)_____(W)_____(C)_____

Auto Accident_____ State Occurred _____Date of Injury_____

Direct Access yes/no Chief Complaint _____
Are you under a Doctor's care? _____ Doctor's name _____
*Note after 30 days, if the episode of care is to continue, the patient will require a script.

*I give consent to release all records to my doctor. (If identified above)

Signature_____Date_____

Assignment of Benefits
I authorize payment of medical benefits to myself or the named provider for professional services rendered.
Signed_____Date_____
Release of Information
I authorize the release of any medical information necessary to process this claim.

Signed_____Date_____

If mailing address is different than street address, please write the mailing address below:

_____

_____