CATALYST PHYSICAL THERAPY

CLIENT REGISTRATION FORM

First Date of Service _____

Full Name: _____

Address: _____ City, St, Zip: _____

Birthdate: _____ Age: _____ SSN#: _____

Phone: _____ *circle one: home cell work*

Email: _____

Appointment Reminders: *circle one: text voicemail email*

Would you like our newsletter emailed to you? *Yes No*

Would you like your payment receipts and/or statements emailed to you? *Yes No*

Emergency Contact: _____ Phone: _____ Relationship: _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Have you had Physical Therapy previously this year? _____ ***Where:*** _____

Insurance Company: _____

ID# or Policy#: _____ Group #: _____

Claims Address: _____

Medicare #: _____ ***Medicaid #:*** _____

MVA# or Work Comp Claim #: _____ Injury Date: _____

Attorney or Adjuster: _____ Contact Phone#: _____

DIAGNOSIS

Referring Physician: _____

Primary DX: _____ Addl DXs: _____

I authorize the release of any medical information necessary to process this claim.

Signature: _____ Date: _____