REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Today's date:	Primary Care Physician:	Date of Injury/Surgery:

EMAIL ADDRESS

Patient's last name	First Name	Middle Name	Marital status (Circle one) S M D W

Social Security #	Home Phone # ( )	Cell Phone # ( )	Birthdate / /	Age:	Sex: M F

Street address:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone # ( )

How did you hear about Dynamix? (please check one box): ❑ Friend ❑Family ☐ Other________________

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Carrier:	Policy ID #	Group #	Phone # ( )
Secondary Insurance Carrier:	Policy ID #	Group #	Phone # ( )

Insured name:	Insured S.S. #	Insured Birthdate:

Occupation:	Employer:	Employer address:	Employer phone # ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Person responsible for bill:	#☐Birthdate: / /	Address:

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone # ( )	Work phone # ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Dynamix Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Dynamix Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

(CONTINUE ON BACK)