



Robert L. Oakeson, PT  
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**PATIENT REGISTRATION FORM**

IF FORM IS NOT COMPLETE WE CANNOT BILL YOUR INSURANCE

PATIENT NAME: \_\_\_\_\_ RESPONSIBLE PARTY FOR MINOR: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
HOME PH: \_\_\_\_\_ BUS. PH: \_\_\_\_\_ CELL PH: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ SEX: Male Female BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
PT. SS #: \_\_\_\_\_ RESP. PARTY SS #: \_\_\_\_\_ RELATIONSHIP TO PT: SELF SPOUSE PARENT OTHER  
HOW WERE YOU REFERRED TO OUR OFFICE (PLEASE CIRCLE): ONLINE INSURANCE COMPANY FRIEND/FAMILY DOCTOR'S OFFICE  
REFERRING PHYSICIAN: \_\_\_\_\_  
PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
IF INJURY IS RELATED TO AN ACCIDENT, Was it an: Auto Accident Job Related Injury DATE OF INJURY: \_\_\_\_\_  
IS PATIENT (PLEASE CIRCLE): SINGLE MARRIED OTHER IS PATIENT (PLEASE CIRCLE): EMPLOYED STUDENT RETIRED  
PT. EMPLOYER NAME AND ADDRESS: \_\_\_\_\_  
PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_  
PHONE/ADDRESS OF PERSON ABOVE: \_\_\_\_\_

**INSURANCE INFORMATION:**

**INDUSTRIAL/WORKERS' COMPENSATION**

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_  
INSURANCE CO. NAME: \_\_\_\_\_ INSURANCE CO. NAME: \_\_\_\_\_  
INS. CO. ADDRESS: \_\_\_\_\_ INSURANCE CO. ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
POLICY NO. \_\_\_\_\_ GROUP/CLAIM NO. \_\_\_\_\_ POLICY NO. \_\_\_\_\_ GROUP/CLAIM NO. \_\_\_\_\_  
POLICY HOLDER SEX: F M BIRTHDATE: \_\_\_\_\_ POLICY HOLDER SEX: F M BIRTHDATE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS:** I hereby authorize this provider/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my provider's participation with my health plan. Release of medical data includes re-disclosure of medical information obtained from other providers in accordance with your wishes.

SIGNED (patient, parent or legal guardian if minor): \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIAZTION TO PAY:** I hereby authorize payment directly to the business office of this provider/clinic for the medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED (patient, parent or legal guardian if minor): \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO TREAT:** I hereby authorize the physical therapist, athletic trainers, therapy aides or other authorized medical personnel of Oakeson Physical Therapy to treat the above patient.

SIGNED (patient, parent of legal guardian if minor): \_\_\_\_\_ DATE: \_\_\_\_\_