

# Alaska Physical Therapy Specialists, P.C.

3650 LAKE OTIS PARKWAY, SUITE 201 ANCHORAGE, AK 99508

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## REGISTRATION FORM

(Please Print)

Appt Date: \_\_\_/\_\_\_/\_\_\_ Appt Time: \_\_\_\_\_ Therapist: \_\_\_\_\_ Chart # \_\_\_\_\_

### PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this a work/auto injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so what state is the claim in?	Date of Injury		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		City	State	ZIP Code	Social Security	Home Phone No. ( )
Mailing address:		City	State	ZIP Code		
Employer:	Employer address:			Employer Phone No. ( )		
Chose Clinic Because/Referred to Clinic by (Please check one box)				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		

Reason for visit today: \_\_\_\_\_ :

### INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer	Employer Address		Employer Phone No. ( )
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance			
<input type="checkbox"/> BCBS	<input type="checkbox"/> Aetna	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Cigna
<input type="checkbox"/> Principal Financial	<input type="checkbox"/> Tricare Standard	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Other _____ (Please provide coupon)			

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Policy #	Group #	Co-Pay \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of Secondary Insurance (if applicable)			Subscriber's Name	Policy #	Group #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
			Birth Date	/ /	

### IN CASE OF EMERGENCY

Person to contact:	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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The above information is true to the best of my knowledge. All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used as follows only with patient consent. I hereby authorize Alaska Physical Therapy Specialists, P.C. to furnish information to other providers, health care or treatment facilities and my insurance companies for purposes of treatment, payment and health care operations. I hereby assign to the provider all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by my insurances.

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE DATE