



LAKESIDE MANUAL PHYSICAL THERAPY, INC.
9445 Zachary Taylor Highway
Unionville, VA 22567-2126
540-854-0367 – Fax: 540-854-0369

**M A N U A L
P H Y S I C A L
T H E R A P Y**

REGISTRATION FORM

(Please Print)

Today's Date _____ / _____ / _____

Referring Doctor _____

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security		Home Phone No. ()
P.O. Box		City		State	ZIP Code		
Occupation		Employer			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 _____			

Other Family Members Seen Here _____

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	()			
Occupation	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"/> Medicare <input type="checkbox"/> Anthem BCBS <input type="checkbox"/> Other						
Subscriber's Name		Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Lakeside Manual Physical Therapy, Inc. I understand that I am financially responsible for any balance. I also authorize Lakeside Manual Physical Therapy, Inc. or insurance company to release any information required to process my claims.

X _____
 PATIENT/GUARDIAN SIGNATURE DATE