



**M O V E M E N T
S Y S T E M S**

Physical Therapy, P.S.

(206) 405-1864 (206) 405-4376 fax



PATIENT REGISTRATION – PLEASE PRINT

Patient _____ Today's date _____
Last name First name Middle Initial

Address _____
City State Zip

Email _____

_____ Initial to provide permission to contact you by email.

Phone () _____ () _____ () _____ SSN# _____
Home Work Mobile

Birthdate _____ Sex Male Female Marital Status Single Married Other

Employed Full time Part time Student Full time Part time

Employer/School Name _____ Occupation _____

Employer's address _____
City State Zip

Emergency Contact _____ Relationship to patient _____

Emergency Phone Number () _____ () _____ () _____
Home Work Cell

Patient's relationship to insured: Self Spouse Child Dependent

IF INSURED IS NOT THE PATIENT, PLEASE COMPLETE THIS SECTION:

Name of insured: _____ Birthdate: _____ Sex Male Female
Last name First name M.I.

Insured's address _____
City State Zip

Phone () _____ () _____ () _____ SSN# _____
home work cell

Employer _____ Employer's address _____
City State Zip

PLEASE PROVIDE THE FRONT DESK WITH YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

Primary Insurance _____ ID number _____ Group number _____

Secondary Insurance _____ ID number _____ Group number _____

NOTE: We do not bill for secondary insurance plans. We require this information to ensure your provider is credentialed with your secondary insurance plan.

Name of referring physician or nonphysician practitioner (NPP): _____
First name Last name Designation

Physician/NPP address: _____
City State Zip

Physician/NPP phone number () _____ Fax number () _____

IF THIS IS AN L&I CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION

Labor and Industry Claim Number : _____

Claim Manager: _____ PHONE () _____

IF THIS IS A PERSONAL INJURY CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION

Name of Auto Insurance Company: _____

Adjuster/Claim Manager Name: _____

Claims Address: _____
Street City State Zip

Phone () _____ Claim #: _____

❖ Please note that Co-pays are collected at the time of visit.

Patient's or authorized person's signature:

- I authorize the release of any medical records or other information necessary to process this claim.

Signed _____ Date _____

Insured's or authorized person's signature:

- I authorize payment of medical benefits to MOVEMENT SYSTEMS PHYSICAL THERAPY, P.S.
- I am financially responsible for any balance due.

Signed _____ Date _____