PATIENT SIGN-IN SHEET

Today's Date: _____

PATIENT INFORMATION

NAME: _____ BIRTHDATE: _____ AGE: _____
LAST FIRST MIDDLE

SEX: M/F Circle One: MARRIED SINGLE DIVORCED WIDOWED

ADDRESS: _____
STREET CITY STATE ZIP

PHONE NUMBER: HOME: ( ) _____ WORK: ( ) _____

DRIVER'S LICENSE NUMBER: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____
(BUSINESS) STREET CITY STATE ZIP

REFERRED BY: _____
NAME ADDRESS PHONE

SPOUSE OR PARENT

NAME: _____

EMPLOYER: _____ WORK PHONE: ( ) _____

ADDRESS: _____
(BUSINESS) STREET CITY STATE ZIP

IN CASE OF EMERGENCY (Other than Spouse)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NUMBER: ( ) _____
STREET CITY STATE ZIP

ASSIGNMENT OF BENEFITS

ASSIGNMENT AND RELEASE:
I authorize payment of benefits to be made directly to REISCHL PHYSICAL THERAPY and understand I am responsible for charges not covered by this assignment. We ask the person who is financially responsible, call your insurance to verify coverage for physical therapy. We want you to be informed that REISCHL PHYSICAL THERAPY is **NOT** a provider in every Health Plan. I also authorize the release of any information requested to process this claim.

_____ _____
DATE PATIENT, PARENT OR GUARDIAN SIGNATURE