www.sobelfamilymedicine.com

SOBEL FAMILY MEDICINE PHYSICAL THERAPY & CHIROPACTIC CARE — **PATIENT REGISTRATION**

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Please fill out the information below. *Thank You For Joining Our Practice!*

Last Name:________________ First Name:________________ M.I.______ DOB:___/___/___ Age:____
Sex: M__F__ Marital Status:_________ Drivers Lic#:______________ State:______ Soc.Sec.#____-_____-_____
Address:______________________ City:______________ State:_________ Zip:__________
Home Ph: (____)__________ Name & Ph# Closest Relative *(not living with you)*________________(____)__________
Cell Ph: (____)__________ E-mail:____________________

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

Responsible Party (Parent or Guardian):________________ Relation to Patient:______________
Address:______________________ City: ______________ State:______ Zip:________
Drivers Lic#:______________ State:_______ Soc. Sec.#____-_____-____ Home Ph:(___)__________
DOB:___/___/___ Employer of Respon. Party:________________ Work Ph:(____)__________

PATIENT EMPLOYER INFORMATION

Employer:______________ Occupation:____________ Work Ph:(____)__________ Ext:_____
Address: ______________________ City:______________ State:______ Zip:_______

INSURANCE DATA

Primary Insurance:______________ Policy Number:______________
Insurance Address:______________________________
Group Number:______________ Policy Owner______________
Relation to Patient______________________ DOB of Policy Owner___/___/___

Secondary Insurance:______________ Policy Number:______________
Insurance Address:______________________________
Group Number:______________ Policy Owner______________
Relation to Patient______________________ DOB of Policy Owner___/___/___

KNOWN ALLERGIES:______________________________
Medications currently taking & dosage:______________________________
____

Referred By:______________________________

CONSENT FOR TREATMENT / INSURANCE AUTHORIZATION & ASSIGNMENT

I give my consent for medical treatment by the doctors and medical staff of Sobel Family Medicine & Physical Therapy. I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits directly to Sobel Family Medicine & Physical Therapy. **I understand the policy of this office is that payment in full is required at the time of service. I understand I am responsible for payment in full for services not covered by my insurance company.**

Signature of Patient______________________

Signature of Responsible Party (if different)______________________ Date:____/____/____