NEW PATIENT REGISTRATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #:	SEX: MALE FEMALE

HOME ADDRESS	CITY	STATE CA	ZIP CODE
HOME PHONE	**CELL PHONE**	WORK PHONE	WHICH DO YOU PREFER WE USE?

MARITAL STATUS SINGLE MARRIED OTHER **EMPLOYMENT** PART TIME FULL TIME OTHER **STUDENT** PART TIME FULL TIME OTHER	EMAIL ADDRESS

EMPLOYER/SCHOOL	TITLE/POSITION	ADDRESS	CITY	STATE	ZIP

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST NAME		
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	UPIN (Office use only)	NPI (Office se only)

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	MI	ADDRESS	PHONE #	CELL #

RELATIONSHIP	INSURANCE SUBSCRIBER NAME	INSURANCE SUBSCRIBER DATE OF BIRTH	PHONE #

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	MEMBER ID NUMBER	GROUP NAME

BILLING ADDRESS	CITY	STATE	ZIP CODE	PHONE #

POLICY HOLDER NAME (IF OTHER THAN PATIENT	PHONE #	CELL #	DATE OF BIRTH	SEX: MALE FEMALE

SOCIAL SECURITY	EMPLOYER NAME	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE INFORMATION						
PRIMARY INSURANCE COMPANY NAME	MEMBER ID NUMBER				GROUP NAME	
BILLING ADDRESS	CITY	STATE	ZIP CODE		PHONE #	
POLICY HOLDER NAME (IF OTHER THAN PATIENT)	PHONE #	CELL #		DATE OF BIRTH		SEX: MALE Female
SOCIAL SECURITY	EMPLOYER NAME		RELATIONSHIP TO PATIENT			

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION /CONSENT TO TREAT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO RAPHA PHYSCIAL THERAPY, INC. IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE(S). IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. NEGOTIATED INSURANCE DISCOUNTS WILL NOT APPLY WHEN REIMBURSEMENT IS MADE BY OTHER PAYER SOURCES, I.E. ATTORNEY'S, ATTORNEY LIENS, OR THIRD PARTY INSURANCES. PAYMENT IN FULL PER THE CLINIC'S FEE SCHEDULE IS EXPECTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF RAPHA PHYSICAL THERAPY INC., AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

X____________________________________ ________________________

AUTHORIZED SIGNATURE DATE

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBLE PARTY SIGNATURE TODAY'S DATE

X

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are you allergic to: ☒ Shellfish _______ ☒ IV Contrast Dye_________ ☒ Penicillins_______

Please list other Food, Medication or Insect Allergies	Describe your reaction

Are you allergic to latex? YES _______ NO ________

Race:
A ▫American Indian or Alaska Native
B ▫Asian
C ▫Black or African American
D ▫ Hispanic Latino
E ▫ Native Hawaiian or Other Pacific Islander
F ▫ White
G ▫ Other

Ethnicity:
A ▫Hispanic or Latino
B ▫Not Hispanic or Latino

Language:
A ▫English understood
B ▫Interpreter needed
C ▫Language you speak most often:______________________

SOCIAL HISTORY

Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?

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