alliant
physical therapy &
integral medicine

PATIENT REGISTRATION

Name _____ Date _____
Last **First** **MI**

Mailing Address_____
Street **City** **State** **Zip Code**

Physical Address_____
Street **City** **State** **Zip Code**

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Contact Preference: ☐ Home ☐ Work ☐ Cell E-mail Address_____

Social Security Number _____Birth date _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner; Registered in: _____ Spouse/Partner's Name_____ ☐ Divorced ☐ Widowed

Employer _____Employer's Address_____

Primary Care Physician _____Referring Physician _____

Emergency Contact_____Relationship_____

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred_____

Claim Number_____ Insurance Company (worker's comp or your auto PIP) _____

Address_____ Claims Adjuster_____ Phone number_____

I hereby authorize assignment of benefits, my commitment to financial responsibility, and my consent to participate in my own (or my dependent's) care services via Alliant Continuum Care, PLLC dba 'Alliant Physical Therapy & Integral Medicine.'

(Signature) _____ (Date) _____

Please tell us how you learned of our service or whom we can thank

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
☐ **Health Club/Professional** recommendation
☐ **Family/Friend/Co-Worker** recommendation
☐ **Doctor** recommendation
☐ **Radio** advertisement
☐ **Yellow Page** advertisement
☐ Found you on the **Internet**
Website: _____
☐ **TV/Billboard** advertisement
☐ **Publication/Newspaper** advertisement
Publication: _____
☐ **Clinic Sign**
☐ Saw you at an **Event**
Event: _____