



Amelia Physical Therapy Registration Form for Minors

Patient Name _____
Last First Middle initial Nickname

Street Address _____

City _____ State _____ Zip _____

Phone (H) _____ Date of Birth _____ Age _____ Male/Female

Insurance Plan _____ How did you find out about this Practice _____

Policy Holder's Name _____ Date of Birth _____

Address of Policy Holder _____

Referring Physician _____

Email or Text Reminder? (Circle one and if text reminder, provide carrier's name)

*Email Address _____ Cell Phone _____ Carrier _____

Please provide email address so we can send you a survey at the end of treatment.

Emergency Contact:

Name _____ Relationship _____

Phone(H) _____ (W) _____ (C) _____

Auto Accident _____ State Occurred _____ Date of Injury _____

Direct Access yes/no Chief Complaint _____

Are you under a Doctor's care? _____ Doctor's name _____

*Note after 30 days, if the episode of care is to continue, the patient will require a script.

*I give consent to release all records to my doctor. (If identified above)

Signature _____ Date _____

Assignment of Benefits

I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed _____ Date _____

Release of Information

I authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____

If mailing address is different than street address, please write the mailing address below:

