APPALACHIAN PHYSICAL MEDICINE
REGISTRATION FORM

NAME: _____
First Middle Last

ADDRESS: _____
Street City State Zip

BIRTHDATE: _____ DRIVER'S LICENSE #: _____

PHONE #: (_____) _____ CELL #: (_____) _____

MARITAL STATUS: S M W D SOCIAL SECURITY #: _____

PLACE OF EMPLOYMENT: _____ POSITION: _____

EMPLOYER ADDRESS: _____ WORK #: _____

NAME & PHONE # OF NEAREST RELATIVE NOT LIVING WITH YOU:

_____

IF YOU ARE CURRENTLY UNDER ANOTHER PHYSICIAN(S) CARE, PLEASE LIST:

_____

SPOUSE INFORMATION:

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

SOCIAL SECURITY #: _____ CELL #: (_____)_____

PLACE OF EMPLOYMENT: _____ POSITION: _____

EMPLOYER ADDRESS: _____WORK #: _____

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD

For valuable consideration, I understand that I am financially responsible for paying any medical expenses in full at the time of service. I authorize my insurance carrier to pay Appalachian Physical Medicine any claims filed by them for services for the named patient. I authorize Appalachian Physical Medicine to release medical information requested by my insurance company.

DATE: _____ SIGNATURE: _____

May we leave a message on your home voice mail if we need to reach you? ☐ Yes ☐ No

May we leave a message with anyone at your home? ☐ Yes ☐ No If yes, whom?_____

May we call you at work? ☐ Yes ☐ No