



**PHYSICAL MEDICINE INSTITUTE**  
**2020 Oakley Seaver Dr., Suite 1 Clermont FL 34711**  
**Phone: (352)404-6959 Fax: (352) 404-6960**

**REGISTRATION FORM**

Today's Date: _____				PRIMARY CARE PROVIDER:				
<b>PATIENT INFORMATION</b>								
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former name):		Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street address:			Social Security no.:		Home phone no.: (    )			
P.O. box:		City:		State:		ZIP Code:		
Occupation:		Employer:			Employer phone no.: (    )			
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan <input type="checkbox"/> Hospital		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other				
Other family members seen here:								
<b>INSURANCE INFORMATION</b>								
(Please give your insurance card to the receptionist.)								
Person responsible for bill:		Birth date:		Address (if different):		Home phone no.: (    )		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:		Employer:		Employer address:		Employer phone no.: (    )		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> CIGNA		
<input type="checkbox"/> Preferred Care		<input type="checkbox"/> Citrus		<input type="checkbox"/> AvMed		<input type="checkbox"/> Blue Cross Blue Shield		
<input type="checkbox"/> Other _____								
Subscriber's name:		Subscriber's S.S. no.:		Birth date:		Group no.:		
						Policy no.:		
						Co-payment: \$		
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:		Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other		
Auto Injury/Work Comp?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Injury:		Place of Injury:		Attorney:		
<b>IN CASE OF EMERGENCY</b>								
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: (    )		Work phone no.: (    )	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Physical Medicine Institute or insurance company to release any information required to process my claims.								
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>				