AGADA
PHYSICAL THERAPY &
INTEGRATIVE HEALTH CENTER

Client Registration Form

Last Name: ______________________ First Name: ______________________ M.I.: ______

Sex: M / F SS#:____________________ E-mail: _________________________________

Home Phone: ________________ Work Phone: __________________ Cell: _________________

Home Address: ______________________________ City/State/Zip: ______________________

Referring Doctor (or self): _______________________ # of visits ordered by MD: ___________

If under 18, who
will be responsible
adult for account: _____________________________ Relationship to patient: _________________

Primary Health Insurance Company- *we need this information regardless of whether or not you are covered by Worker's Compensation, Auto Insurance or Personal Liability.

Insurance Company Name: ____
Member ID #: ______________________________________ Group #:____________________

Policyholder name
If other than patient: ______________________________________ Policy Holder DOB: _________________

Patient Relationship to Policyholder: ____

Secondary Health Insurance Company (if applicable)
Insurance Company Name: ____

Member ID #: ______________________________________ Group #:____________________

Policyholder name
If other than patient: ______________________________________ Policy Holder DOB: _________________

Patient Relationship to Policyholder: ____

Workers Compensation, Auto Insurance or Personal Liability (if applicable)

How were you injured? Work Auto Liability Date of Injury: ________________________

Employer at the time of injury: _________________________________ State accident occurred: ______________

Adjuster's Name: __________________________________ Adjuster's Phone #: ______________________________

Insurance Carrier Name and Address: ____

Your File or Claim Number: ____