



REGISTRATION FORM

Today's Date: ___/___/___

Estimated onset date of symptoms
of which you are receiving therapy: ___/___/___

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____

Date of Birth: ___/___/___ Age: ___ Sex: M F Social Security #: ___-___-___

Marital Status: _____ Occupation: _____ Employer: _____

Home/Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home: ___-___-___ Cell/Other: ___-___-___ Referring Physician: _____
(Please circle preferred method of phone contact)

Is the condition for which you are referred to therapy related to an auto accident or
worker's compensation? YES NO

Have you received outpatient physical, occupational, or speech therapy in 2023? YES NO

Are you currently receiving home healthcare? YES NO

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist

Primary Insurance: _____ Patient's Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: ___/___/___
(if different from Patient) (if different from Patient)

Secondary Insurance: _____ Patient's Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: ___/___/___
(if different from Patient) (if different from Patient)

IN CASE OF EMERGENCY

Name of local relative or
friend: _____ Relationship: _____ Phone #: ___-___-___
(living at different address)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the facility. I understand that I am financially responsible for any balance. I also authorize Minnesota Therapy & Balance Center LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: ___/___/___