NORTHWOODS THERAPY PATIENT REGISTRATION
PLEASE FILL IN ALL INFORMATION COMPLETELY

PATIENT NAME____ DATE _________________________

ADDRESS ________________________________ CITY ___________________________ STATE_______ ZIP______________

CELL PHONE___________________________ HOME __________________________ WORK __________________________

BIRTHDATE_________________ MALE_______ FEMALE ______ EMPLOYER _____________________________________

EMAIL____ REFERRING DOCTOR_________________________________

NAME OF RESPONSIBLE PARTY/ADDRESS____
(if different from above)

CHECK THE CORRESPONDING BOX TO CHOOSE FROM A TEXT MESSAGE OR VOICE REMINDERS FOR APPOINTMENTS:

☐ TEXT REMINDER ☐ VOICE REMINDER ☐ NO REMINDER

IS THIS CONDITION WORK-RELATED? YES NO /

DATE OF INJURY__________________________

AUTO ACCIDENT? YES NO
IF YES, DATE OF ACCIDENT__________________

STATE WHERE OCCURRED___________________

PRIMARY INSURANCE:

NAME OF PERSON WHO CARRIES THE INSURANCE____ DOB_____________

SECONDARY INSURANCE: INSURED'S NAME____ DOB_____________

IF TRICARE/VA PLAN, SOC SEC #________________________________

EMERGENCY CONTACT INFORMATION:

	Name:	Phone Number:	Relationship to Patient:
1.			
2.			

AUTHORIZATION FOR RELEASE OF INFORMATION AND BILLING

I authorize Northwoods Therapy, their physicians, and other personnel to discuss my health and billing information, in person or by telephone, with the following family members or friends involved in my medical care. This authorization will remain in effect for an unlimited amount of time unless otherwise noted or revoked.

	Name:	Relationship to patient:
1.		
2.		

I hereby authorize my insurance benefits to be paid directly to NORTHWOODS THERAPY ASSOCIATES, realizing I am responsible for any charges remaining after payment of insurance benefits and for any non-covered services. I also hereby authorize the release of pertinent medical information to insurance carriers for the purpose of payment or determination of benefits.
Copies of the Written Notice of Privacy Practice from NORTHWOODS THERAPY ASSOCIATES are available to me in the waiting room or upon my request.

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Patient or Personal Representative Signature **Date**