POW PHYSICAL THERAPY
Pilates, **O**rthopedics, **W**omen's Health

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Patient Registration

Last Name:_____ First:_____ Middle:_____

Date of Birth:_____/_____/_____ Age:_____ Sex: M F Marital Status:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Employer:_____ Occupation:_____

Work Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Fax: _____

***Please circle the phone number above that is the best to contact you.

E- Mail address:_____

Emergency Contact:_____ Phone:_____

Address: _____ City:_____ State:_____ Zip:_____

Relationship to you:_____

Referred by:_____

Primary Physician:_____ Phone:_____

Would you like to receive confirmation of your appointments? Y N

If so, do you prefer e-mail or phone confirmations?_____

I hereby authorize POW Physical Therapy to release my medical information to my insurance company for the purpose of payment. I hereby authorize and direct my insurance company to pay POW Physical Therapy directly. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due.

Sign:_____ Date:_____