



## NEW PATIENT REGISTRATION FORM

Patient's Name \_\_\_\_\_  
 Last First Middle Initial  
 Street Address \_\_\_\_\_  
 City State Zip  
 Mailing Address \_\_\_\_\_  
 City State Zip  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Sex  Male  Female  
 Driver's License Number \_\_\_\_\_  
 Patient's Status  Single  Married  Other Date of Injury \_\_\_\_\_

Are you currently receiving ANY Home Health Services  Yes  No

### Employer:

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City State Zip

Employer at time of Injury (if different): \_\_\_\_\_

HOW DID YOU HEAR ABOUT STRIVE?  Doctor  Friend/Relative  Advertisement  
 Phone Book  Other \_\_\_\_\_

### WHO MAY WE CONTACT IN CASE OF EMERGENCY?

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Relationship \_\_\_\_\_

### ALL STUDENTS MUST COMPLETE THIS SECTION WITH A PERMANENT ADDRESS AND THE RESPONSIBLE PARTY'S INFORMATION

Are you an athlete? YES NO  
 If yes, please name the school, college or organization: \_\_\_\_\_

### How were you injured?

Was this at a school sponsored event? YES NO

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer Name \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # \_\_\_\_\_

### AUTHORIZATION FOR TREATMENT

I authorize Strive Physical Therapy Centers, its employees and agents as well as any and all independent contractors engaged by Strive to perform the services on my behalf as they may deem necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_

OVER →



**INSURANCE INFORMATION** (check one please)  MC  Champus  Auto  BC/BS  
 WC  AvMed  HPSE  Cigna  
 OTHER \_\_\_\_\_

**PLEASE FILL OUT THE INFORMATION BELOW IF YOU ARE NOT THE PRIMARY SUBSCRIBER ON THE INSURANCE CARD**

Subscriber's Name \_\_\_\_\_ SS# \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Insurance Name \_\_\_\_\_

Street Address \_\_\_\_\_  
City State Zip

Subscriber's Number \_\_\_\_\_ Group Number \_\_\_\_\_

Employer Name \_\_\_\_\_

Street Address \_\_\_\_\_  
City State Zip

Secondary Insurance \_\_\_\_\_

