Sims
Physical Therapy, Inc.

2530 Professional Parkway Santa Maria, CA 93455 Phn: 805-928-4465 Fax#: 805-928-7935
915 E. Stowell Rd. STE D Santa Maria, CA 93454 Phn#: 805-314-2567 Fax: 805-928-7935

Patient Registration

A. Patient Information

Last Name:	First Name:	MI:	Suffix:

Gender: M F	SSN#:	DOB:

Address:

City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:

Email Address: To receive **Statements via Email** check here □

□Exclude from **Appointment reminders**? (if box checked you will not receive an email to remind you of appointments)

Employment status: □Employed □Unemployed □Retired □Student □Disabled □Other

Employer Name:

B. Emergency Contact

Relationship to Patient: □Spouse □Parent □Child □Grandparent □Sibling □Friend □Other

First Name:	Middle Initial:	Last Name:
Home Phone:	Work Phone:	Cell Phone:

Preferred Contact Method: □Home Phone □Work Phone □ Cell Phone

C. Spouse Information or Guarantor/ Responsible Party

Relationship to Patient: □Parent □Grandparent □Legal Guardian □Other □Spouse

First Name:	Middle Initial:	Last Name:
Home Phone:	Work Phone:	Cell Phone:
DOB:	SSN:	

D. Accident Information

Was your injury as a result of a work related or Auto Accident □Yes □No If Yes, □Work □ Auto

Work Comp or Auto Insurance Name:

Phone#:	Policy#:	Claim#:
Adjuster Name:	Accident Date:	Accident State:

E. Insurance (if applicable)

Primary Insurance (copy of card must be on file): □ Check here if Name, SSN & DOB same as patient

Insurance Name:

Subscriber (insured) Name:

Relationship of Patient to Subscriber: □Self □Spouse □Child □Other

SSN#:	DOB (mm/dd/yy):

Secondary Insurance (copy of card must be on file): Check here □ if Name, SSN, & DOB same as patient

Insurance Name:

Subscriber(Insured) Name:

Relationship of Patient to Subscriber: □Self □Spouse □Child □Other

SSN#:	DOB (mm/dd/yy):

Patient Signature:	Date