Balance and Neurologic Center of the Rockies

*Specializing in Neurologic Physical Therapy*

# Patient Registration

| **Patient:** | **Date:** |
|---|---|

| | | |
|---|---|---|
| Street Address/PO Box: | | |
| City: | State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: |
| Email: | D.O.B: | Social Security #: |
| Gender: Male ☐ Female ☐ | Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ | |
| Employment: F/T ☐ P/T ☐ Unempl. ☐ Ret. ☐ Student ☐ | Appt. Reminder Preference: Email ☐ Text ☐ Phone ☐ | |
| Employer: | Occupation: | |
| Employer Address: | | |
| Emergency Contact Phone: | | |

| | | |
|---|---|---|
| **Primary Insurance Information** | | |
| Primary Insurance Company Name: | | Phone: |
| Primary Insurance Company Address: | | |
| Name of Insured: | ID #: | Group #: |
| **Secondary Insurance Information** | | |
| Secondary Insurance Company Name: | | Phone: |
| Secondary Insurance Company Address: | | |
| Name of Insured: | ID #: | Group #: |
| **Motor Vehicle Accident Injury Information/ not applicable** | | |
| Your Auto Insurance Carrier: | | Phone: |
| Auto Insurance Carrier Address: | | |
| Name of Insured: | Date of injury: | Claim #: |
| Adjuster Name: | | |
| **Motor Vehicle Accident Injury Information/ not applicable** | | |
| Your Auto Insurance Carrier: | | Phone: |
| Auto Insurance Carrier Address: | | |
| Name of Insured: | Date of injury: | Claim #: |
| Adjuster Name: | | |
| **Job Related Injury Information/ not applicable** | | |
| Employer When Injured: | | Date of Injury: |
| Employer's Workers Comp. Carrier: | | Claim #: |
| Workers Comp Carrier Address: | | |
| Workers Comp Carrier Phone: | Claim Status: Open ☐ Closed ☐ New ☐ Disputed ☐ | |