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**WELCOME TO TRI-CITY PHYSICAL THERAPY**  
**PATIENT REGISTRATION**

PATIENT NAME: \_\_\_\_\_  
Last First M.I

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVER'S LICENSE #: \_\_\_\_\_

TEL #: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ EMERGENCY TEL # \_\_\_\_\_

SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ SEPARATED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_

SEX: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ GE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ (M) \_\_\_\_\_ (D) \_\_\_\_\_ (Y)

PATIENT'S EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TEL #: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_

WORK HISTORY: JOB TITLE \_\_\_\_\_ # OF YEARS: \_\_\_\_\_

ARE YOU CURRENTLY WORKING? YES \_\_\_\_\_ NO \_\_\_\_\_ LAST DATE WORKED \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ AUTO \_\_\_\_\_ INDUSTRIAL \_\_\_\_\_ PRIVATE \_\_\_\_\_ MEDICARE \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

HAVE YOU HAD PHYSICAL THERAPY BEFORE? YES \_\_\_\_\_ NO \_\_\_\_\_ WHEN \_\_\_\_\_

WHAT PART OF BODY? \_\_\_\_\_

PRIMARY CARE DR. \_\_\_\_\_ TEL # \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ATTORNEY REPRESENTING YOU: \_\_\_\_\_ TEL # \_\_\_\_\_

**CANCELLATION AND NO-SHOW POLICY:**

- **We require 24 hours proper notice in the event of a cancellation.** It is the patient's responsibility.
- **There is a \$20.00 charge for improper cancellation and no-shows.** The patient should understand that this charge will not be covered by insurance, but will have to be paid by them personally.
- The staff may exercise discretion in certain circumstances on a first "no-show" or improper cancellation.

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Tri-City Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I hereby authorized Tri-City Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission. I also consent to receive physical therapy treatment prescribed by my physician.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_