Tri-City Physical Therapy

2805 Whipple Road
Union City, CA 94587
Tel: 510-441-8906 Fax: 510-441-8908

39210 State St, #202
Fremont, CA 94538
Tel: 510-790-9480 Fax: 510-790-9490

www.tricitypt.com

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_____ BIRTHDATE: _____ (MM) _____ (DD) _____ (YYYY)

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:

- **It is the patient's responsibility to provide 24 hours' notice in the event of cancellation of appointment.**
- **There is a $20.00 charge for cancellation and no-shows within 24 hours of scheduled appointment time. This charge will not be covered by insurance, and will be the patient's responsibility.**
- **The staff may exercise discretion in certain circumstances on a first "no-show" or 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: _____