PATIENT'S REGISTRATION

IGNITE PHYSICAL THERAPY & WELLNESS CENTER, LLC

Patient's First Name: _____ Last Name: _____

Guardian's Information: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Birth Date: _____/_____/_____ Marital Status: _____ Gender: _____M _____F

Social Security Number: _____-_____-_____

E-Mail Address: _____

Employer Name: _____ Work Phone #: _____

Occupation: _____

Person to Contact in Case of Emergency: _____

Is this Auto No-Fault or Worker's Compensation case? _____

Insurance Company Name: _____

Insurance ID: _____ Group: _____

Who referred you to us? _____

Authorization and Assignment

I hereby authorize Ignite Physical Therapy & Wellness Center to release information necessary to my insurance company in order to process claims for charges incurred by me, and I release Ignite Physical Therapy & Wellness Center of any consequence thereof. In consideration of the services rendered to me by Ignite Physical Therapy & Wellness Center, I authorize and direct my insurance carrier to remit payment directly to Ignite Physical Therapy & Wellness Center.

Signature: _____ Date: _____

665 Broadway, Bayonne, NJ 07002 ***info@ignitetherapy.com*** ***ph: 201-875-5757 : f: 201-455-6691***