HULST JEPSEN
PHYSICAL THERAPY

Patient Registration Form

Patient First Name: _____M.I._____ Last Name: _____

What you prefer to be called: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Social Security number: _____

Mailing Address: _____
PO Box -or- Street Address Apt./Suite/Building #

_____
City State Zip

Home Phone: (___)_____ Cell Phone: (___)_____

Email Address: _____ ☐ Opt-out of Email Reminders
NOTE: This information will NOT be sold for marketing purposes! ☐ Opt- out of all HJPT Emails

PCP/Family Physician name: _____ Employer/School _____

Insurance

Insurance Subscriber Name: _____

Insurance Subscriber DOB: _____Relationship to Patient:_____

Has the patient been to the chiropractor this year? _____Yes _____No

If patient is a minor who should receive any possible bills or correspondence?

Name: _____Relationship to Patient:_____

Address:_____ Phone #:_____

Is your injury due to any of the following: Work Injury Auto Accident School Injury Other Accident
Please Circle If Yes

If yes to any of the above, you have to provide us with claim information in order for us to bill for your injury/accident

Release of Protected Health Information

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

How did you hear about us? (Please check all that apply)

☐ Previous patient ☐ Friend ☐ Relative ☐ Insurance ☐ Website ☐ Doctor ☐ Advertising ☐ Social Media
☐ Other (please specify)_____

X_____

Signature of patient or personal representative Date