LEXINGTON PHYSICAL THERAPY ASSOCIATES
REGISTRATION

Date_____

Name_____ **Date of birth**_____

Address_____ **City**_____ **State**____ **Zip**_____

Home phone_____ **Cellphone**_____ **Workphone**_____

Email address_____

I would like to receive appointment reminders by:
Email_____ **Text**_____ **Voice on: cell#**_____ **Home#**_____ **Work#**_____

Employer_____ **Occupation**_____

Employer address_____

INSURANCE INFORMATION

Name of insurance_____ **ID#**_____

Subscriber_____ **Relationship**_____

Subscribers address (if different than patient address)

_____

Subscribers date of birth_____

Employer_____ **Occupation**_____

Employer address_____

EMERCENCY CONTACT INFORMATION

Name_____ **Phone**_____

Relationship_____

PHYSICIAN INFORMATION

Primary_____ **Phone**_____

Referring physician_____ **Phone**_____