GEORGE FOX UNIVERSITY
PHYSICAL THERAPY CLINIC

Patient Registration

Last Name	First	MI		Date	
Physical Address	Apt#	City	State	Zip	
Mailing Address	Apt#	City	State	Zip	
Home Phone # ( )	Work Phone # ( )			Cell Phone # ( )	
Contact Preference ☐ Home ☐ Work ☐ Cell	Ok to leave a message? ☐ Yes ☐ No			E-mail Address	
Social Security Number	Date of birth			Sex ☐ Male ☐ Female	
Employer				Employer's Address	
Primary Care Physician				Referring Physician	
Emergency Contact	Relationship			Phone # ( )	
Primary Insurance					
Subscriber's Name				Birth date	
ID Number				Group Number	
Secondary Insurance					
Subscriber's Name				Birth date	
ID Number				Group Number	

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

☐Doctor ☐I was a former patient ☐Family/Friend/Co-worker recommendation ☐Love INC ☐Friend's View

☐George Fox Website ☐Internet Other_____

I verify that the above information is accurate.

PATIENT SIGNATURE_____ DATE_____

PARENT, GUARDIAN, RESPONSIBLE PARTY_____ DATE_____

I _____ (name) attest that there is no ongoing legal action surrounding my condition. This includes, but is not limited to, open litigation (lawsuit), an open motor vehicle accident case, a Workers' Compensation case, or personal damages case. I attest that no legal action is connected to the condition I am seeking treatment for. _____ (signature) _____(date)