Staszak Physical Therapy
& Wellness Center

488 E. 11th Ave. Suite 150A • Eugene, Oregon 97401
tel: 541.505.8180 • fax: 541.505.7134
staszakpt.com

PATIENT REGISTRATION

PATIENT INFORMATION

Name:_____ Nickname:_____ Date of Birth:_____ Sex: M / F

Mailing Address:_____ City:_____ State:____ Zip Code: _____

Primary Phone #:_____ Secondary Phone#: _____ Email:_____

Referring Physician:_____ Primary Care Physician: _____

How did you hear about us? _____

RESPONSIBLE PARTY INFORMATION *(IF PATIENT IS UNDER 18 YEARS OLD)*

Guarantor Name:_____ Date of Birth:_____ Sex: M / F

Mailing Address:_____ City:_____ State:____ Zip Code: _____

Primary Phone #:_____ Secondary Phone#: _____ Email:_____

Employer Name:_____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company:_____ Insurance Phone:_____

Subscriber Name: _____ Date of Birth:_____

Subscriber ID:_____ Policy/Group #:_____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company:_____ Insurance Phone:_____

Subscriber Name: _____ Date of Birth:_____

Subscriber ID:_____ Policy/Group #:_____

MVA/WORKER'S COMP INSURANCE INFORMATION

Name of MVA/WC Insurance:_____ Claim #:_____

Adjuster:_____ Phone # & Ext.:_____

Date of Injury:_____State:_____ Employer: _____

I certify that the above information is true and correct to the best of my knowledge. I authorize Staszak Physical Therapy & Wellness Center to furnish any and all insurance information necessary to process all claims and agree to the assignment of insurance benefits to them. I authorize Staszak Physical Therapy & Wellness Center to contact me via the above listed email for periodic newsletters and promotional specials.

_____ _____ _____ _____

Patient Signature (Age 18 and Over) Date Guarantor Signature Date

_____ _____ _____

Printed Patient Name Printed Guarantor Name Relationship to Patient