1805 South Bellaire Street
#235
Denver, CO 80222

Ashbaugh Physical Therapy, PC

Phone: 303-756-3388
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Paula Ashbaugh, MPT, ATC
Jason Lund, MSPT

PATIENT REGISTRATION:

Patient Info:

Full Name: ______________________ Birth Date: __________ Gender: M F

Mailing Address: ______________________
City: ______________________ State: ________ Zip: ______________

Home Phone: ( ) ______________________ Work: ( ) ______________________

Cell: ( ) ______________________ Email Address: ______________________

Emergency Contact: ______________________ Phone: ( ) ______________________

My condition is related to: ☐ Work ☐ Auto Accident ☐ Other: ______________________

Social Security #: ______________________ Marital Status: ______________

Occupation: ______________________ Work Status: ☐ Employed ☐ Student ☐ Retired ☐ Disabled

Employer Name: ______________________ Employer Address: ______________________

Employer Phone: ______________________ Dentist: ______________________

How did you hear about us? ______________________

Medical History:

Please check any boxes that apply to your health history to help us ensure your safety with treatment:

☐ Osteoporosis	☐ Diabetes	☐ Heart Attack
☐ Osteopenia	☐ Asthma	☐ High Blood Pressure
☐ Seizures/Stroke	☐ Bleeding Disorder	☐ Chest Pain/Angina
☐ Cancer	☐ Blood Clot	☐ Other: ______________

Surgical History: ______________________

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Please list any medications you are currently taking: ______________________

Payment Info:

INSURANCE/NON-CASH Payers:

☐ I have insurance and would like you to deal directly with them. I will assign my benefits over to you.

☐ I was injured on the job and my employer's insurance will be paying the bills.
The insurance company is: ______________________ Claim #: ______________________

☐ I was injured in a car accident.
The insurance company is: ______________________ Claim # ______________________

CASH Payers:

☐ I am paying out of pocket for services. Please give me a point of service discount.

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I also understand that I am responsible for all copays, deductibles, and portions of my bill not covered by my insurance company or denied by Workman's Compensation. I certify that I and/or my dependents have insurances stated above, and assign benefits directly to Ashbaugh Physical Therapy, P.C.

______________________________ ______________
Signature of Patient or Guardian: Date: