STRIDE™
PHYSICAL THERAPY & PEDORTHIC CENTER

Stride, Inc. • 80 Turnpike Drive, Unit One • Middlebury, Ct 06762
Tel: 203-758-8307 • 800-787-7879
Fax: 203-758-8394 • www.strideorthotics.com

REGISTRATION FORM

Patient's Name:_____ Date of Birth:_____
Marital Status: M D S W SS#:_____
Home Phone:_____ Work Phone:_____ Cell:_____
Street Address:_____
City:_____ State:_____ Zip:_____
E-Mail Address:_____ **For Future Specials/Refurbishment Reminders***
Employer:_____
Employer Address:_____
Person to contact in case of emergency:_____ Phone:_____
(Closest relative not living with you)
Was this due to an accident? Y N Auto_____ Work_____ Other_____
Where were you injured?_____ Date of Injury:_____
Do you have an attorney representing you? Y N Name:_____
Attorney Address:_____
Primary Insurance Co:_____ ID:_____
Group:_____ Subscriber:_____ Date of Birth:_____
Employer:_____ Occupation:_____
Secondary Insurance Co:_____ ID:_____
Group:_____ Subscriber:_____ Date of Birth:_____
Employer:_____ Occupation:_____
Height:_____ **Weight:**_____ **Shoe Size:**_____ **Shoe Style:**_____
Primary Care Physician:_____ Phone:_____
Referring Physician:_____ Phone:_____
Allergies:_____
Current Medications:_____
Check Conditions that apply to you:
Heart Disease____ Respiratory____ Diabetes____ Seizure____ Stroke____ Cancer____
Smoker Y N Surgery:_____ Date:_____ Reason:_____
_____

<u>BILLING INFORMATION</u> (please complete this section only if bills are to be sent to someone other than the person described above - otherwise write "same")
Name of person to bill:_____
Address:_____
Home Phone:_____ Work Phone:_____ Cell:_____
Relationship to patient:_____

<u>FINANCIAL DISCLOSURE/PATIENT SIGNATURE</u>

I have been informed at this time that my pedorthic device, which has been prescribed to me by my physician, may not be covered by insurance. I understand that any remaining balance is my responsibility. I hereby assign all medical benefits to be paid directly to Stride PT & Pedorthic Center. I authorize disclosure of my records to my insurance carrier, lawyer and referring doctor. I also release any medical information necessary to process my claim. I do hereby agree and give my consent for Stride PT & Pedorthic Center to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Parent/Guardian Signature:_____ Date:_____