



Tonic Physical Therapy New Patient Registration Form

Name of Patient _____ D.O.B _____

Telephone

Cell (____) _____

Home (____) _____

Work (____) _____

Email Address: _____

Address: _____

Occupation: _____

Employer: _____

Emergency Contact _____

Telephone/email _____

Payments are due on the day of your visit. A valid credit card is needed on file.

*****LATE CANCELLATIONS NO SHOWS** will be automatically charged. See *Informed Consent* form or cancellation time frame and policy .

Card Type: __Visa __MasterCard __American Express **Security Code _____

Credit Card # _____

Exp: _____

Patient Signature _____

Date: _____