



# MONTOYA

## PHYSICAL THERAPY AND WELLNESS

Dr. Rick C. Montoya, PT, DPT  
Dr. Kelly Montoya, PT, DPT  
Robert Dator, PTA

### Patient Registration

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*\*\*Please circle the phone number above that is the best to contact you

E- Mail address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like to receive confirmation of your appointments? Y N

How did you find out about us? \_\_\_\_\_

I hereby authorize Montoya Physical Therapy and Wellness to release my medical information to my insurance company for the purpose of payment. I hereby authorize and direct my insurance company to pay Montoya Physical Therapy directly. I understand that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due.