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PDG Therapeutics New Client Registration Form

Please be aware that if you do not cancel your evaluation 24 hours in advance, you will not be able to re-schedule services at PDG Therapeutics, unless you chose to pay a \$75 fee which will be collected before you are re-scheduled. ALL documents are required. Please sign them prior to your appointment, or arrive early so we can answer any questions you may have about the intake packet.

Client's Name: _____

Date of Birth: _____ **SS#:** _____

Client's Gender: _____ **Client's Ethnicity:** _____

Address: _____

E-Mail: _____

Insurance Name: _____ **Member ID#:** _____

Authorization Obtained: _____

Deductible: _____ **Co-pay:** _____

***Bring your insurance card and driver's license. We will need the insurance holder's information if you are not the primary policy holder for billing purposes if you have private insurance.**

Insured Name: _____ **DOB:** _____

Employer/Address & phone #: _____

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____