**Park Avenue Physical Therapy**
**Patient Information**
(**PLEASE USE BLACK INK ONLY**)

Patient Name: ________________________________ Age:_______________ Date: _____________
Address: ________________________________________ City: ____________________ Zip: _________
SS#: ______-_______-_______ Date of Birth: _____/______/_____ Home #: ________________
Cell #: ________________
**Would you like a notification by text _____ and/or email _____ to remind you of your appointment?**
**If so, please provide an email address**: ____________________________________________________
Employer Name _______________________________________
Primary Care Physician Name:______________________________________________________________
Parent or Legal Guardian Name (If patient is a minor): ___________________________________________
Address: ____________________________________ City: __________________ Zip: ___________
Home #: ________________ Cell #: ____________________

**Insurance:**
Primary Insurance: _________________________________________________________________________
Identification #: __________________________ Suffix#: ______________ Group #: _______________
Policy Holder Name: ______________________ Policy Holder SS#: ______-_______-_______
Policy Holder Date of Birth: _____/______/_____ Relation to Patient: ______________________

Secondary Insurance: _______________________________________________________________________
Identification #: __________________________ Suffix#: ______________ Group #: _______________
Policy Holder Name: ______________________ Policy Holder SS#: ______-_______-_______
Policy Holder Date of Birth: _____/______/_____ Relation to Patient: ______________________

**No Fault & Workers' Compensation:** You must supply the date of injury/accident and the necessary case and compensation numbers. You **must** also give your major medical information in the above section.

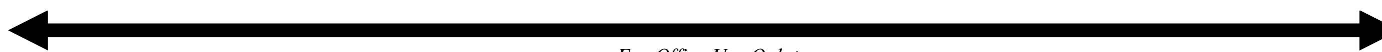
No Fault: _______ Comp: _________ Date of Accident/Injury: _____/______/_____
Insurance Carrier Name: ____________________________________________________________________
Insurance Address: ___________________________________ City: __________________ Zip:_________
WCB Case#: ___________________ Carrier Case#: _______________ Additional #: _____________

**Patient Authorization:** I authorize the release of any medical information necessary to process my insurance claim. I authorize the release of my medical records to my physical therapist. I authorize payment of medical benefits to Park Avenue Physical Therapy for services rendered.

If ***Professional Collections*** are necessary, the patient will incur additional fees. The Guarantor will be responsible if the patient is a minor.

Print Name: ___________________________________ Signature: ________________________________
Date: _____/______/_____

**How did you hear about us?**
Referred by a Previous Patient ____________ Referred by a Physician ________________
Phone Book ___________________________ Other ________________________________



*For Office Use Only:*

Therapist: ____________________ Diagnosis: ______________________________ Date of Initial Evaluation: ______/______/______

Doctor: __________________________________________ NPI #: ____________________________________