

Central Physical Therapy Patient Information Form

Welcome! Thank you for selecting our practice. All information will be strictly confidential.

PLEASE PRINT LEGIBLY

Patient Information:

Name: First _____ Last _____

Social Security Number: _____

Address: Street _____

City _____ State/County _____ Zip Code _____

Phone: Daytime/Cell _____ Evening _____

Email: _____

Date of Birth (MM/DD/YYYY) _____

If Child, **Parent/Guardian's Name:** _____

Who referred you to Central Physical Therapy?: _____

Physician's Information: Name _____

Physician's Phone _____ Physician's Fax _____

In case of emergency, please provide us with 2 emergency contacts:

Name: First _____ Last _____

Phone: _____ Email: _____

Relationship: _____

Name: First _____ Last _____

Phone: _____ Email: _____

Relationship: _____

Do you require any special assistance? (Parking needs, mobility issues, allergies/sensitivities): Yes _____ No _____

If yes, please specify: _____

Employer: _____ **Occupation:** _____

Address: Street _____

City _____ State/County _____ Zip Code _____

Primary Health Insurance Information: Carrier Name _____

Subscriber's Name: First _____ Last _____

Subscriber's Date of Birth (MM/DD/YYYY) _____

Relationship to the Subscriber _____

Subscriber's Address (if different from patient): Street _____

City _____ State/County _____ Zip Code _____

Phone: _____ Email: _____

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Secondary Health Insurance Information: Carrier Name _____
Subscriber's Name: First _____ Last _____
Subscriber's Date of Birth (MM/DD/YYYY) _____
Relationship to the Subscriber _____
Subscriber's Address (if different from patient): Street _____
City _____ State/County _____ Zip Code _____
Phone: _____ Email: _____
Is this a worker's compensation: Yes _____ No _____ Case #: _____
Is this an automobile accident: Yes _____ No _____ Case #: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to:

Central Physical Therapy for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

CONSENT TO TREAT

I hereby authorize the professional staff at **Central Physical Therapy** to examine & treat me for the injury I have been referred here for or referred myself to.

Patient Name (Printed)

Signature

Date

Parent/Guardian
Name(Printed)

Signature

Date

Central Physical Therapy, LLC
571 Central Ave., Suite# 106
New Providence, NJ 07974