NEW YORK PHYSICAL THERAPY
68 S. Central Avenue
Valley Stream, New York 11580
T 516.825.1112
F 516.256.0503
W nyptvs.com

PATIENT INFORMATION

Today's Date:_____

Name:_____ ☐ Male ☐ Female
First MI Last

Address:_____
Street Address Apt# City State Zip Code

Phone #'s: (___) ___-___ (___) ___-___ (___) ___-___
Home Phone Work Phone Cell Phone

Email:_____@_____ Date of Birth:___/___/___ Age:_____ Social Security#:___-___-___
For Appointment Reminders Month Day Year

Employer:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact:_____ Emergency Phone#: (___) ___-___

Person Responsible for Charges (If patient is UNDER 18 Years of Age):_____ Relationship to Patient:_____

Social Security# of insured:___-___-___

INSURANCE INFORMATION

Is this case: ☐ Workers Compensation ☐ No-Fault ☐ Private Insurance

Are you CURRENTLY being treated by another Physical Therapist/Chiropractor for this injury? ☐ Yes ☐ No

(Medicare Patients Only) Have you had Home Physical Therapy? ☐ Yes ☐ No

(Medicare Patients Only) Do you have a Home Health Aide? ☐ Yes ☐ No

Private/Medicare Insurance

Name of Policy Holder:_____ Insurance Carrier's Name:_____

Policy#_____ Group#_____

Secondary Insurance

Name of Policy Holder:_____ Insurance Carrier's Name:_____

Policy#_____ Group#_____

Work Related Injury (Worker's Compensation)

Employer's Workman's Compensation Carrier_____

Case Adjustor(if known):_____ Phone #: (___) ___-___

Address:_____

WCB Case#_____

Auto Related Injury (No-Fault)

Name of Policy Holder:_____ Insurance Company Name:_____

Policy#_____ Claim#_____

Attorney Name:_____ Attorney Phone#: (___) ___-___

Reviewed by_____