PATIENT REGISTRATION FORM

Please read carefully and complete by printing in ink. Provide all information requested.

PATIENT REASON FOR VISIT: ______________________________ **DATE:** __________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

PATIENT: This section refers to patient only

Last Name	First Name	MI	Address: Street and Number, Apt. # / Box #	
City	State	Zip	Home Telephone ( )	Work Telephone ( )
Social Security No.		Date-of-Birth		Age
Employer Name			Employer Address: Street and Number, Box #	
City	State	Zip	Type of Business	
Marital Status	Sex M F	Source of Referral (please circle whether Patient or Physician Name:		
Spouse/Guardian	Address: Street and Number, Box #			Apt
City	State	Zip	Home Telephone ( )	Work Telephone ( )
Social Security No. Spouse		Date-of-Birth Spouse		Age Spouse
Spouse's Employer		Employer's Address: Street and Number, Box #		
City	State	Zip	Type of Business	
Emergency Telephone	Emergency Contact	Relationship		

INSURANCE INFORMATION: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-AUTHORIZATION APPROVAL, PLEASE BE SURE TO TELL US.

Comp./No-Fault/Private		D/O/A		Carrier Case#	
If No-Fault, Insurance Carrier Name		Address: Street and Number, Box#			
City	State	Zip	Phone Number ( )	Contact Person	
Policy Holder		Policy#		Group#	
Attorney Name		Address: Street and Number, Box#			
City	State	Zip	Phone Number ( )		
Referring Physician Name	Address: Street and Number, Box#		City	State	Zip

PRIVATE INSURANCE: Complete Below:

PRIMARY Insurance Plan			Policy No.		Group No.
Copay amount ($)		Effective Date			Termination Date
Subscriber Name		Patient Relationship to Subscriber			
Insurance Company Address	City		State	Zip	Insurance Company Telephone No. ( )

SECONDARY Insurance Plan			Policy No.		Group No.
Copay amount ($)		Effective Date			Termination Date
Subscriber Name		Patient Relationship to Subscriber			
Insurance Company Address	City		State	Zip	Insurance Company Telephone No. ( )

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s), to Bronx Physical Therapy, LLP
2. I authorize and request payment of medical benefits directly to my physicians, BRONX PHYSICAL THERAPY.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original.