



PATIENT INFORMATION

Last Name: _____ First _____ Middle Initial _____

State: _____ City _____ House#/Street: _____ Zip: _____

Home Phone () _____ Work Phone () _____

Social Security # _____ Sex Male Female Date of Birth: _____

Employer: _____ Occupation: _____

Employment: Full Time Part Time Retired Not Employed

Marital Status: Married Single Student Status: Full-Time Part-Time Not a Student

INSURANCE INFORMATION- If your condition is the result of a work or auto-related accident immediately inform the receptionist so we may give you the appropriate paperwork.

Primary Insurance: _____

Name of Insured _____ Employer of Insured: _____

Relationship to Insured: Self Spouse Child Step-Child Other: _____

Insurance ID # _____ Insured Date of Birth: _____

Secondary Insurance _____

Name of Insured _____ Employer of Insured: _____

Relationship to Insured: Self Spouse Child Step-Child Other: _____

Insurance ID # _____ Insured Date of Birth: _____

PLEASE READ BEFORE SIGNING:

I authorize Advance Physical Therapy, P.C. to release any information to my insurance company that is necessary to expedite the payments of my claims. I understand that I am responsible for all charges not covered by my insurance company including co-payments, co-insurances, and deductibles. IF ADVANCE PHYSICAL THERAPY, P.C. IS FORCED TO SEND MY ACCOUNT TO A COLLECTIONS AGENCY, I UNDERSTAND I WILL BE CHARGED THE FULL BALANCE OF MY ACCOUNT AS WELL AS ANY INCURRED COLLECTION FEES.

Patient Signature (or parent/ legal guardian) _____ Date: _____

Questions??

Contact us by:

Phone: 516-568-4444

FAX: 516-679-2684

E-Mail:

lobergh@Advance-pt.com



PATIENT HISTORY

Full Name: _____ Date: _____ Age: _____ Sex Male Female

Please give the condition you want treated? _____ Height _____ Weight _____ (Mandatory for Medicare pts)

How long have you had this complaint? _____ Referring Physician: _____

Is your injury the result of a work or auto related accident? Yes No If yes: Work Auto

Have you previously had this condition? If yes ,explain: _____

List all previous physical therapy and other treatments you have received for your condition: _____

Have you had any physical therapy treatment in the past year? (Please list dates/#visits) _____

List all of your medical conditions so we can safely evaluate and treat you (ex: high blood pressure, allergies, cardiac conditions, past surgeries, pregnancy, etc.):

Please list all medications (prescription and over the counter or supplements) you are currently taking _____

How did you come to our practice? I am a former patient My insurance Company Website

I saw your ad in the yellow pages I am a World Gym member

Doctor _____ Drs. Office staff member(list name) _____

Family Member or Friend (please name so we may thank them) _____ OTHER _____

I visited your web site Direct Web Search Google Search Bing/Yahoo Search

Privacy Policy Acknowledgement: Advance PT will share your information **only** as it relates to your treatment. A copy of our privacy policies is always available at our front desk and waiting area. **Please sign below** acknowledging our policy and its availability. **Please Sign Here:** _____

PLEASE CALL US WITH ANY QUESTIONS: 516-568-4444