WELCOME TO WEST SIDE PHYSICAL THERAPY

Your assistance in providing the information below is needed to correctly process insurance billing. If you have any questions, please ask the receptionist. Thank you for choosing West Side Physical Therapy, P.C.

Name:______________________________ Social Security #: ____________________

Address:____ Apt #:___________

City:______________________________State:______Zip Code:______________

Date of Birth:___________ Sex:M/F (circle one) Email:_____________________

Phone:(H) ( )________________ (W) ( )______________(Cell)___________

Next of Kin:_______________________________Phone: ( )_________________

Referring Physician: _______________________Office Location:______________

Type of Injury:____________________________Date of Injury:_______________

Employer:__________________________Occupation:________________________

How you heard about West Side P.T.: (check any that apply)

( ) Dr.'s Recommendation | **( ) Friend's Recommendation**
( ) Advertisement | **( ) Prior Injury Treated Here**
( ) Plaza Location (signs) | **( ) Other**

PLEASE PROVIDE US WITH COPIES OF YOUR INSURANCE CARDS IF YOU HAVE PRIVATE INSURANCE or MEDICARE.

DATE OF BIRTH OF SUBSCRIBER: __/__/______

Please fill in this section if your injury is Work Related/Auto Related

Insurance Carrier:________________________WCB#______________________

Address:_______________________________________Claim#_________________

____Phone: ( )_________________

Contact Person (Case Manager):_________________________Phone Ext.________

Have you ever had any other treatment for this condition?_____________________

____

When is your next doctor's appt. scheduled?__________________________________

Please list any medications you are currently taking:__________________________

____

Are you currently working? Yes / No If no, last date of work__________________

Do you now, or have you ever had any of the following conditions:

_______Diabetes	**_______Heart Disease**	**______Dizziness**
______High Blood Pressure	**______Heart Attack**	**______Seizures**
______Pacemaker	**______Migraine Headaches**	
______Kidney Problems	**______Nervous Disorders**	
______Allergies to Heat	**______Allergies to Ice**	
______Hernia	**______Pregnant (currently)**	
______Metal Implants	**______HIV Positive**	
______Cancer	**Other:____**	

Previous Surgery & Dates:____

____

Patient Release

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I authorize a copy of this release to be used in place of the original.

I understand and agree that I am financially responsible and liable for payment of all charges assessed to me for the professional services rendered by West Side Physical Therapy, P.C.. I understand that insurance claims will be submitted to my insurance company as a matter of courtesy and that I am ultimately responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payments for Physical Therapy services to me, I will deliver such payment to West Side Physical Therapy, P.C.

I understand and agree that if it becomes necessary for West Side Physical Therapy, P.C. to commence any legal action or to obtain an attorney for collection of any outstanding balances on my account, I will be responsible for all reasonable fees incurred by West Side Physical Therapy, P.C., in addition to the outstanding balance due.

Signature:____Date:_______________