



**PATIENT INFORMATION**  
*"This information is confidential"*

Today's Date: \_\_\_\_\_

Cell: \_\_\_\_\_

Patient Name – Last, First, MI	E-Mail:
Address	

City – State – Zip Code	Home Telephone
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Sex Male      Female	Age	Date of Birth	Social Security Number	Marital Status (Circle One) Single   Married   Widowed Divorced
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Employer	Occupation	Business Telephone Number
Spouse's Name	Spouse's Employer	Spouse Business Telephone No.

**\*\*\*\* IF PATIENT IS A MINOR, PLEASE FILL OUT PARENT/GUARDIAN INFORMATION BELOW \*\*\*\***

Father	Employer	Business Telephone
Mother	Employer	Business Telephone

Local Friend/Relative <u>not</u> at same address	Telephone (   )	Relationship
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**If Applicable:**  
 Who referred you?    Physician    Friend/or former Patient-Name \_\_\_\_\_    Yellow Pages    Other:  
 \_\_\_\_\_  
 If Physician: Name \_\_\_\_\_    Clinic \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Address \_\_\_\_\_    City \_\_\_\_\_    State \_\_\_\_\_    Zip \_\_\_\_\_  
 Code \_\_\_\_\_

**I hereby authorize you to release medical information about me to my referring Physician:    YES    NO**

**INSURANCE INFORMATION – Please show your card to the receptionist. If you are unable to provide this information, you will be responsible for filing claims to your insurance company.**

<b>Primary Insurance</b>	Group #	Policy #	Policy Holder Name	Policy Holder Date of Birth:
Insurance Company Address	City	State	Zip Code	Telephone
<b>Secondary Insurance</b>	Group #	Policy #	Policy Holder Name	Policy Holder Date of Birth:
Insurance Company Address	City	State	Zip Code	Telephone

**Treatment Authorization** – I hereby authorize Orenstein Physical Therapy, or their designee(s), to treat my or the patient's condition as they deem appropriate.

**Assignment of Benefits** – I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to Orenstein Physical Therapy for any services rendered to me by or on behalf of Orenstein Physical Therapy.

**Medicare Patients** – I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orenstein Physical Therapy for any services furnished me by that organization. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**Records Release to Insurance Carrier(s) and Other Payers** – I hereby authorize Orenstein Physical Therapy to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, or to billing partners, any information including my complete health record needed to determine benefits for services provided by or on behalf of Orenstein Physical Therapy.

***"I understand that I am financially responsible for charges not covered under my insurance policy".***

FOR ALL OF THE ABOVE INFORMATION: \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_