ORENSTEIN
PHYSICAL THERAPY

PATIENT INFORMATION

"This information is confidential"

Today's Date: _____

Cell:

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

City – State – Zip Code	Home Telephone

Sex Male Female	Age	Date of Birth	Social Security Number	Marital Status (Circle One) Single Married Widowed Divorced

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

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.

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

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

<u>Assignment of Benefits</u> – *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**