Park Avenue Physical Therapy
Patient Information
(PLEASE USE BLACK INK ONLY)

Patient Name: _____ Age:_____
Address: _____ City: _____ Zip: _____
SS#: _____-_____-_____ Date of Birth: _____/_____/_____ Home #: _____
Cell #: _____

Would you like a notification by text _____ and/or email _____ to remind you of your appointment?
If so, please provide an email address: _____
Primary Care Physician Name:_____
Parent or Legal Guardian Name (If patient is a minor): _____
Address: _____ City: _____ Zip: _____
Home #: _____ Cell #: _____

Insurance:
Primary Insurance: _____
Identification #: _____ Suffix#: _____ Group #: _____
Policy Holder Name: _____ Relation to Patient: _____
Policy Holder Date of Birth: _____/_____/_____

Secondary Insurance: _____
Identification #: _____ Suffix#: _____ Group #: _____
Policy Holder Name: _____ Relation to Patient: _____
Policy Holder Date of Birth: _____/_____/_____

No Fault & Workers' Compensation: You must supply the date of injury/accident and the necessary case and compensation numbers. You **must** also give your major medical information in the above section.

No Fault: _____ Comp: _____ Date of Accident/Injury: _____/_____/_____
Insurance Carrier Name: _____
Insurance Address: _____ City: _____ Zip:_____
WCB Case#: _____ Carrier Case#: _____
Claim #: _____
Employer:_____
Employer Address:_____ City:_____ Zip:_____

Patient Authorization: I authorize the release of any medical information necessary to process my insurance claim. I authorize the release of my medical records to my physical therapist. I authorize payment of medical benefits to
Park Avenue Physical Therapy for services rendered. I hereby consent to receive autodialed, pre-recorded, or SMS Text calls from or on behalf of TND Physical Therapy at the telephone number provided, including wireless number provided. I understand that consent is not a condition of purchase or services received.
If ***Professional Collections*** are necessary, the patient will incur additional fees. The Guarantor will be responsible if the patient is a minor.

Print Name: _____ Signature: _____
Date: _____/_____/_____
How did you hear about us?
Referred by a Previous Patient _____ Referred by a Physician _____
Phone Book _____ Other _____

For Office Use Only:
Therapist: _____ Diagnosis: _____ Date of Initial Evaluation: _____/_____/_____

Doctor: _____ NPI #: _____