Grand Central Physical Therapy / Hand Therapy

-New Patient Information-

Patient Name: ____
Last Name First Name Initial

Home Phone: _________________________ Email Address: ______________________________________

Address: ____

City: _______________________ State: _________________ Zip Code: ____________________________

SS # ______________________ Sex: M____F____ Age: _________ Date of Birth: _____/_______/_______

Single: _____ Married: _____ Separated: _____ Divorced: _____

Patient Employed By: ___________________________________ Occupation: _______________________

Business Address: _____________________________________ Business Phone: _______________________

How did you hear of Grand Central Physical/Hand Therapy? _______________________________________

Referring M.D. ____________________ In case of emergency who should be notified? _______________

Phone: ______________________________ Relation to Patient: ___________________________________

Is your diagnosis due to a work or auto related accident? Yes ______ No______ Is there litigation involved? Yes ______ No ______

-Insurance Information-

Person Responsible for Account: ____
Last Name First Name

Relationship to Patient: _________________________________ Person's Date of Birth: _____/______/_____

Address (If different from that of patient's): ____

City: _______________ State: _______________ Zip Code: ______________ Phone: __________________

Person Responsible Employed By: _______________________________ Occupation: __________________

Business Address: ____ Business Phone: ______________________

Insurance Company/Address: ____

Policy # ______________________ Group # ____________________ SS # ___________________________

-Release Authorization-

Please fill out & sign the following release. We will process your insurance forms. I, the undersigned certify that I or my dependent have insurance coverage with (name of Insurance Company) ____________________________.

I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the use of this signature on all insurance submissions.

Signature: ____ **Date:** ________/________/________