NEW AGE PHYSICAL THERAPY
32-07 FRANCIS LEWIS BLVD
BAYSIDE, NY 11358
(P) 718 224 3818 (F) 718 224 0784

Patient Information Form – *Please complete entire form.*

Personal Information

Patient's Name: ______________________________ Date: ____ / ___ / ____
FIRST MI LAST

Address: ______________________________
STREET ADDRESS CITY STATE ZIP CODE

SS #: ________ - _______ - ____________ Date of Birth: _____ / ___ / ________ SEX: ______________

Home Phone #: (_____)__________________ Cell Phone #: (_____)________________________

Emergency Contact Name: ______________________________ Phone #: ____________________

Referring Doctor: ________________________ Primary Care Doctor: ______________________

How did you hear about New Age Physical Therapy? ______________________________________

Insurance Information

Type of Insurance: [ ] Private Insurance [ ] Workers Compensation [ ] No Fault

Please list *all* insurances. If you are being treated for a Workers Compensation case or a No Fault claim, Please list the case/claim under Primary Insurance and your private insurance under Secondary Insurance Information.

Policy Holder's Name: ________________________________ DOB: _____/______/__________

Primary Insurace Carrier: ______________________________ ID# ______________________

Relationship To Primary Insurance Holder: _________________ Secondary ____________________

Policy Holder's Name: ________________________________ DOB: _____/_____/_________

Secondary Insurace Carrier: ______________________________ ID# ____________________

WORKERS COMPENSATION / NO FAULT PATIENT

Date of Accident: _________ Employer's Name: _____________ Adjuster's Name: ______________

Claim # ________________________ Phone: __________________ Fax: ____________________

MEDICARE PATIENTS

Have you received any physical therapy or speech therapy this year? [ ]YES [ ]NO
If yes, where: ____ When: __________________

Have you had Home Health Care in the past 90 days? [ ]YES [ ]NO
If yes, which agency? ______________________________ Date of Discharge: _____________

Medical Information

Reason for Referral/Diagnosis: ______________________________

Do you have now, or have you ever had, any of the following conditions? *Please check all that apply*:

CONDITION	YES	NO	CONDITION	YES	NO
Are you pregnant NOW?			Allergy to Tape/Latex		
Electronic Implant			Bladder/Bowel Problems		
Pacemaker			Osteoporosis		
Rheumatoid Arthritis			Osteoarthritis		
High Blood Pressure			Heart Problems		
Cancer			Seizures		
Diabetes			Asthma		
Alcoholism			Defibrillator		

Are you taking any medications now? Please answer YES or NO. If yes, please list below:

____

____

I authorize New Age Physical Therapy to discuss my medical information with the following:
(indicate all that apply)

Spouse: ______________________________ Phone: ______________

Family Member: ______________________________ Phone: ______________

Doctor: ______________________________ Phone: ______________

Attorney: ______________________________ Phone: ______________

Case/Claim Manager: ______________________________ Phone: ______________

Other: ______________ Relationship: ______________ Phone: ______________

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to which I am entitled, including Medicare, private insurance, major medical and any other plan to New Age Physical Therapy PC/Niravkumar Shah PT/Ami Shah PT. I understand I am responsible for providing all of my insurance information. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand copay/coinsurance is due at the time of service and additional balances will be billed to me. I understand it is possible that my fee for service may be different then the copay/coinsurance amount written on this form. I authorize new age physical therapy and its provider the use of this signature on all insurance submissions. I hereby authorize said assignee to use or disclose all information necessary for treatment, obtaining payment and health care operations. I hereby authorize New Age Physical Therapy PC to perform any medical treatment as deemed necessary. I understand that as a patient I am responsible for maintaining a valid prescription and will contact my doctor's office to obtain an updated one when necessary. I have been notified and signed HIPPA policy. A copy of this policy is available to me upon request.

______________________________ ______________________________

Signature of patient or parent/guardian if minor Date