Patient Information

Name____ ☐ Male ☐ Female
First MI Last

Address____
Street Address Apt # City State Zip Code

Phone #'s: (______) ______-___________ (______) ______-___________ (______) ______-___________
Area Code Home Phone Area Code Work Phone Area Code Cell Phone

Date of Birth ______/_____/______ Age: ______________ Social Security #______-______-_______
Month Day Year

Employer: _____________________________________ Occupation: ______________________________________

IF WORKERS COMPENSATION case, Employer's Name & address:____
____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other **Onset of Current Injury**____/_____/______

Emergency Contact: _________________________________ Phone (______) ______-____________
Area Code

E-mail Address: ____

<u>Physician Information</u>

Referring Physician: ____ Office Phone (_____) ______-__________
First Last Area Code

Primary Care Physician: _____________________________________ Office Phone (_____) ______-__________
First Last Area Code

<u>Primary Insurance Information</u>

Name of Policy Holder ___________________________ ____/_____/______ ______-_______-_________
First Last Date of Birth Social Security Number

Address of Policy Holder ____
(If Different from Above) Street Address City State Zip Code

Relationship to Patient ________________________

<u>Secondary Insurance</u>

Name of Policy Holder ___________________________ ____/_____/______ ______-_______-_________
First Last Date of Birth Social Security Number

Address of Policy Holder ____
(If Different from Above) Street Address City State Zip Code

Relationship to Patient ________________________

Notice of Privacy Policies

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our notice may chance. Upon request, a copy of our revised notice will be made available to you. I **have read and understand the Notice of Privacy Practices.**

COMMUNICATION

I authorize Jersey Physical Therapy to leave detailed messages regarding my Medical information and any Billing/Account balance issues on the secure Phone number and E-mail address I've provided below:

Phone Number: _________________________ E-mail address: _____________________________________

Patient Name: __________________________________

Signature: ____________________________________ Today's Date: _____/______/________
(Parent or Legal Guardian if patient is under 18)