New York Sports And Physical Therapy Institute

2339 Hempstead Turnpike
East Meadow, NY 11554
Phone: (516) 520-3053
Fax: (516) 520-5715

WELCOME TO OUR OFFICE

PATIENT NAME:	**MARITAL STATUS:** S M D W
AKA:	**SEX:** MALE / FEMALE
SOCIAL SECURITY:	**STUDENT:** YES / NO

DATE OF BIRTH:	**AGE:**	**EMPLOYER:**	**OCCUPATION:**
ADDRESS:		**ADDRESS:**	
CITY, STATE:	**ZIP:**	**CITY, STATE:**	**ZIP:**
PHONE (HOME):	**CELL:**	**PHONE (WORK):**	
EMERGENCY CONTACT:		**PHONE # AND RELATIONSHIP:**	

PRIMARY INS. CO:		**POLICYHOLDERS NAME :**	**D.O.B.**
ADDRESS:		**I.D#**	**GROUP #**
CITY, STATE:	**ZIP**	**RELATIONSHIP TO PATIENT:** SELF / SPOUSE / PARENT / GUARDIAN	
SECONDARY INS. CO:		**POLICYHOLDERS NAME :**	**D.O.B**
ADDRESS:		**I.D.#**	**GROUP #**
CITY, STATE:	**ZIP**	**RELATIONSHIP TO PATIENT:** SELF / SPOUSE / PARENT / GUARDIAN	

WAS AN AUTOMOBILE INVOLVED? ☐ **YES** ☐ **NO** **IF YES PLEASE ASK FOR PROPER FORMS**	**WERE YOU INJURED ON THE JOB?** ☐ **YES** ☐ **NO**
DID THIS INJURY OCCUR AT SCHOOL?	**SCHOOL NAME:**
SCHOOL PHONE #:	**SCHOOL INSURANCE CARRIER:**
SCHOOL INSURANCE ADDRESS:	**CITY,STATE:**
DATE OF INJURY:	**ZIP:**
ARE YOU CURRENTLY ENROLLED IN HOME HEALTH CARE ☐ **YES** ☐ **NO**	

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carriers payments. However, the patient is responsible for all fees, co-payments and deductibles, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION ACQUIRED DURING EXAMINATION AND/OR TREATMENT TO MY INSURANCE COMPANY AND/OR TO MY ATTORNEY.

I have read this registration form and state that all information given by me is known to be valid and true.

Patient/Guardian Signature: _____ **Date:** _____