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

MALE / FEMALE SQCIAL SECURITY: STUDENT: VES / NO DATE OF BIRTH: AGE: EMPLOYER: OCCUPATION: ADDRESS: ADDRESS: ADDRESS: Image: City, STATE: ZIP: Image: City, STATE: ZIP: SOTIONE (MOME): CITY, STATE: ZIP: Image: City, STATE: ZIP: Image: City, STATE: D.O.B. PRIMERY INS. CO: POLICYHOLDERS NAME : D.O.B. GROUP # SECONDARY INS. CO: ZIP RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / GUARDIAN SECONDARY INS. CO: ID# GROUP # D.O.B. ADDRESS: ID# GROUP # ID.O.B. SECONDARY INS. CO: POLICYHOLDERS NAME : D.O.B. CITY, STATE: ZIP RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / GUARDIAN SECONDARY INS. CO: ID# GROUP # ID# OR CITY, STATE: ZIP RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / GUARDIAN SCHOD NTE: ZIP NO SELF / SPOUSE / PARENT / GUARDIAN MAS AN AUTOMOBILE INVOLVED? ID# GROUP # ID#	PATIENT NAME:			MARITAL STATUS:	
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DATE OF INJURY: ZIP:	SCHOOL INSURANCE ADDRESS:		CITY,STATE:		
	DATE OF INJURY:		ZIP:		
ARE YOU CURRENTLY ENROLLED IN HOME HEALTH CARE 🛛 YES 🗌 NO	ARE YOU CURRENTLY ENROLLED IN HOME HEA	LTH CARE			

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: