

NY PHYSICAL THERAPY & WELLNESS

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

EMAIL _____

First Name:		Last Name:			M.I.
Address:		City:		State:	Zip:
Birth Date: / /	Age:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	S.S #	Marital Status:
Home Phone:		Alternate Phone(s):			
Chose facility Because/Referred to facility by <input type="checkbox"/> Dr: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family _____					
<input type="checkbox"/> Friend _____ <input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Street Sign <input type="checkbox"/> Yellowbook					
<input type="checkbox"/> Website _____ <input type="checkbox"/> Other _____					

WORK INFORMATION

Employer:	Work Phone ()	Ext
Occupation:	Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone(s): ()
Regular Dr/PCP:	Regular Dr/PCP Phone(s): ()

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Carrier:

Subscriber Name:	Birth Date: / /
I.D.#:	Group / Policy #:
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

Secondary Insurance Carrier:

Subscriber Name:	Birth Date: / /
I.D. #:	Group / Policy #:
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name:	<input type="checkbox"/> Auto:	<input type="checkbox"/> Work/Labor:	<input type="checkbox"/> Slip & Fall
Adjuster/Claim Rep:	Phone: ()	Ext	
Address:	City	State	Zip

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ()	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:		
Relationship to Patient	Home Phone: ()	Alt. Phone: ()