PECONIC PHYSICAL THERAPY

97 Montauk Highway
Hampton Bays, NY 11946
(631) 723-0801

PATIENT DEMOGRAPHIC

Today's Date_____ Referring Doctor _____

Patient's Name _____ Family Doctor _____

Patient's Date of Birth _____ Age _____ Gender _____ Marital Status _____

Home Phone _____ Cell Phone _____ Patient's Social Security # _____

Patient's Mailing Address _____

Emergency Contact _____ Relationship_____ Phone _____

Patient's (parent if minor) Employer _____ Occupation _____

Patient's Employment Address _____

Patient's Employment Telephone Number _____ Insurance Policy Holder Name _____

Patient's E-Mail address_____

IF PATIENT IS NOT INSURANCE POLICY HOLDER, PLEASE COMPLETE THE FOLLOWING:

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's Address ___ (← check here if same) _____

Policy Holder's Social Security Number_____ Age _____

Policy Holder's Employer _____ Phone Number _____

Policy Holder's Employment Address _____

Insurance Information: Please submit all insurance cards to receptionist for photocopying. If you have no insurance, you will be required to pay at the time of service. If your insurance requires a referral and you do not have one, you will be required to pay for the charges incurred.

PRIMARY INSURANCE: **Insurance Carrier** _____

SECONDARY INSURANCE: **Insurance Carrier** _____

I hereby authorize Peconic Physical Therapy to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself.

In the event that the provider's charges are outstanding or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the provider's charges.

_____ _____

Signature of patient **Date**