

All Garden State Physical Therapy, LLC
750 Broadway, Paterson, NJ 07514
973-345-1312
<http://allgardenstatept.com>

PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -		
Home Phone: () -		Alternative Phone (Cell, Pager): () -		Spouse:	
Chose Clinic Because/ Referred to Clinic 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"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <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: () -		
Regular Dr./PCP			Regular Dr./PCP Phone: () -		
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)					
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date : / /	
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date : / /	
ID. #:	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"/> Labor & Industries:		
Adjuster/Claim Manager:			Phone:		Ext.:
Address:		City	State:	Zip:	
Claim #:	Accident Date: / /		Cause:		
ATTORNEY INFORMATION					
Name:		Law Firm:		Phone: () -	
Address		City	State:	Zip:	
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:		Home Phone: () -		Work Phone: () -	

I authorize my insurance benefits be paid directly to All Garden State Physical Therapy. I understand that I am financially responsible for any balance. I also authorize All Garden State Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE _____

DATE _____