Park Avenue Physical Therapy
175 East Main Street, Suite 110●Huntington, NY 11743
Ph: (631) 427-7600 Fax: (631) 427-7636
Patient Registration Form

Last Name:_____ **First Name:**_____ **MI:**_____

Address: _____ **D.O.B.:** _____ **Sex:** M/F

City:_____ **Zip Code:** _____ **Referring Physician:** _____

Phone: Home: _____ **Cell:** _____ **Email:**_____

Work: _____ **Ext:** _____ **Preferred Method of contact:** □ Home □ Cell □ Work

Marital Status: □ Married □ Single □ Divorced □Widowed □ Domestic Partner

Employment Status: □ Employed □ Retired □ Full- time student □ Part-time student □ Other _____

Employer Name: _____

Guarantor: □ Yes □ No **If no: Name: Last:** _____ **First:** _____

Custody: □ Mother □ Father □ Joint □ Legal Guardian **Date of Birth:**_____/_____/_____

Emergency Contact Name: _____ **Phone #:** _____

Primary Insurance Information: *Please Provide Your Insurance Cards to The Receptionist*

Company: _____**Group #:** _____**Co-Payment Amount:** _____

Policy #: _____ **Deductible:** _____

Relationship to Insured: _____

POLICY HOLDER INFORMATION:

Last Name: _____ **First Name:** _____ **MI:** _____

Employer :_____ **Date of Birth:** _____/_____/_____

Secondary Insurance Information:

Company: _____**Group #:** _____**Co-Payment Amount:** _____

Policy #: _____ **Deductible:** _____

Relationship to Insured: _____

POLICY HOLDER INFORMATION:

Last Name: _____ **First Name:** _____ **MI:** _____

Employer :_____ **Date of Birth:** _____/_____/_____

AUTHORIZATION TO PAY BENEFITS TO PARK AVENUE PHYSICAL THERAPY: I hereby authorize payment directly to Park Avenue Physical Therapy, otherwise payable to me for physical therapy services, realizing I am responsible to pay non-covered services. I hereby authorize Park Avenue Physical Therapy to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature (Patient or Parent if Minor) _____**Date:** _____