Align
PHYSICAL THERAPY
& Wellness

971 Route 202n, Suite #2
Branchburg, NJ 08876
Tel: 908-255-4040
Fax: 908-845-8649

Patient Information:

Patient Name: (Last) _____(First) _____(Middle)_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone (cell): _____ Phone(home)_____ Email: _____

Gender: _____

Date of Birth: _____

SS#: (for insurance purposes) _____

Marital Status:

Emergency Contact: _____ Relation: _____ Phone: _____

Occupation: _____

What are we seeing you for? _____

Referring Doctor: _____

Auto/MV Related: Yes / No Work Related: Yes / No Accident Related: Yes / No

Insurance Information:

Primary Insurance Company: _____
Primary Insurance Holder: _____
Policy/ID #: _____
Group #: _____
Phone number: _____
Relation to Patient: Self / Spouse / Dependent Child

Secondary Insurance Company: _____
Secondary Insurance Holder: _____
Policy/ID #: _____
Group #: _____
Phone number: _____
Relation to Patient: Self / Spouse / Dependent Child

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Medical History:

	Yes	No
Anemia		
Anxiety		
Arthritis		
Asthma		
Cancer		
Cardiac conditions		
Cardiac pacemaker		
Dementia		
Depression		
Diabetes		
Dizziness		
Emphysema/Bronchitis		
Gallbladder		
Hepatitis		
High Blood Pressure		
Incontinence		

	Yes	No
Kidney Problems		
Metal implants		
Multiple Sclerosis		
Osteoporosis		
Parkinson's		
Pregnancy		
Rheumatoid Arthritis		
Seizures		
Speech Impairment		
Stroke		
Thyroid		
TB		
Other: Please List		
_____		
_____		
_____		

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Authorization & Consent for Treatment

I consent to Align Physical Therapy and Wellness for treatments/procedures that are necessary or advisable for my care. I authorize Align Physical Therapy and Wellness to exchange with and/or release requested information on my medical care to my insurance carrier and any other parties involved in your case

_____ _____

Patient's Signature Date

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due by my insurer to Align Physical Therapy & Wellness. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Align Physical Therapy and Wellness.

_____ _____

Patient's Signature Date

I have read and understood Align Physical Therapy and Wellness' privacy notice. I further that I may obtain a copy of this privacy notice upon request.

_____ _____

Patient's Signature Date

I have read and understand Align Physical Therapy and Wellness' billing and collection policies, The Financial Policy, cancellation and no-show policies. I further understand that I may obtain a copy of this policy upon my request.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (if patient is a minor) Date