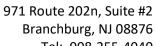


971 Route 202n, Suite #2 Branchburg, NJ 08876 Tel: 908-255-4040

Fax: 908-845-8649

Patient Information:

Patient Name: (Last)	(First)	(Middle)
Street Address:		
	State: Zip:	
Phone (cell):	Phone(home)	Email:
Gender:		
Date of Birth:		
SS#: (for insurance purposes) _		
Marital Status:		
Emergency Contact:	Relation:	Phone:
Occupation:		
Referring Doctor:		
Auto/MV Related: Yes / No	Work Related: Yes / No	Accident Related: Yes / No
Insurance Information:		
Primary Insurance Compan	y:	
Primary Insurance Holde	er:	
Policy/ID	#:	
Group	#:	
Phone number		/ Day and Jay Child
Relation to Patier	it: Self / Spo	ouse / Dependent Child
Secondary Insurance Compan	y:	
Secondary Insurance Holde	•	
Policy/ID		
Group	•	
Phone number		
Relation to Patier	nt: Self / Spo	ouse / Dependent Child



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Medical History:

PHYSICAL THERAPY & Wellness

	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		
ТВ		
Other: Please List		



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Authorization & Consent for Treatment

I consent to Align Physical Therapy and Wellness for treatment my care. I authorize Align Physical Therapy and Wellness to ex- information on my medical care to my insurance carrier and an	schange with and/or release requested
Patient's Signature	Date
I certify that the information furnished by me is correct and her benefits due by my insurer to Align Physical Therapy & Wellne for payment of fees regardless of insurance coverage. I also cer information from Align Physical Therapy and Wellness.	ess. I understand that I am financially responsible
Patient's Signature	Date
I have read and understood Align Physical Therapy and Wellne copy of this privacy notice upon request.	ess' privacy notice. I further that I may obtain a
Patient's Signature	 Date
I have read and understand Align Physical Therapy and Wellne Policy, cancellation and no-show policies. I further understand request.	-
Patient's Signature	Date
Parent or Guardian Signature (if patient is a minor)	Date