

FORT LEE PHYSICAL THERAPY₃₀₁ BRIDGE PLAZA NORTH, FORT LEE, NJ 07024
PATIENT REGISTRATION FORM (PLEASE PRINT CLEARLY)

PATIENT INFORMATION	
Last Name	Home Address
First Name	
Social Security - -	
Date of Birth / /	Home Phone ()
Gender (circle): <i>Male</i> <i>Female</i>	Mobile Phone ()
Marital Status (circle): <i>Single</i> <i>Married</i> <i>Other</i>	Email
Emergency Contact Name	Emergency Contact Phone ()
Relationship to You	Emergency Work Phone ()
EMPLOYMENT INFORMATION	
Employment status (circle): <i>Full-time</i> <i>Part-time</i> <i>N/A-Unemployed</i> <i>Retired</i>	
Disability status, if applicable (circle): <i>Temporary/Short-term</i> <i>Permanent/Long-term</i>	
Employer Name	Employer Address
Work Phone ()	
Occupation	
DOCTOR AND INJURY INFORMATION	
Referring Physician	Referring MD Phone Number ()
Date of Last Visit to Referring MD / /	Referring MD Office (City/Town)
Primary Care Physician	PCP Phone Number ()
Date of Last Visit to PCP / /	PCP Office (City/Town)
Exact/Approx. Date of Injury / /	Date of Surgery, if applicable / /
Is your condition due to (circle): <i>Work-related</i> <i>Car accident/MVA</i> <i>Slip/Fall</i> <i>Sports</i> <i>Other</i>	
INSURANCE INFORMATION (Please complete if your injury is <u>not</u> related to work or a car accident)	
Primary Insurance Company Name	
Policy / ID Number	Group Number (if applicable)
Name of Primary Insured, if not self	
Primary Insured's Social Security - -	Primary Insured's Address
Primary Insured's Date of Birth / /	
Primary Insured's Gender (circle): <i>Male</i> <i>Female</i>	
Secondary Insurance Company Name	
Policy / ID Number	Group Number (if applicable)
Name of Primary Insured, if not self	
Primary Insured's Social Security - -	Primary Insured's Address
Primary Insured's Date of Birth / /	
Primary Insured's Gender (circle): <i>Male</i> <i>Female</i>	

I, (PRINT NAME) _____, authorize Fort Lee Physical Therapy to treat me as per my doctor's prescription and to release to my insurance company/lawyer/employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

Patient Signature _____ Date _____