Southern Tier Physical Therapy of Binghamton, P.C.

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

Date of Birth: _____/_____/_____ **SS#:** _____-_____-_____ **Male** _____ **Female** _____

Permanent Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Marital Status: Single _____ Married _____ Divorced _____ Other _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Employer: _____ **Work Phone:** (_____) _____-_____ **Ext:** _____

Student: YES_____ NO _____ **School Name:** _____

Emergency Contact: _____ **Relation**: _____ **Phone:** (_____) _____-_____

Referring Physician: _____ **Primary Care Physician:** _____

Body Part(s) Being Treated Today: _____ **Date of Injury or Onset:** _____/_____/_____

Is This Condition Related To: Employment _____ Auto Accident _____ Other Accident _____

Have you ever had physical therapy for this injury before? **IF YES,** when & where? _____

Primary Insurance Provider: _____

**** MEDICARE PATIENTS: *Are you currently receiving any Home Health Care Services?* **YES _____ NO _____**

Subscriber's Name (if different than patient): _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's SS#: _____-_____-_____

Relationship to Subscriber: _____ Subscriber's Employer: _____

Insurance Group # _____ Insurance ID # _____

Secondary Insurance Provider (if applicable): _____

Subscriber's Name (if different than patient): _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's SS#: _____-_____-_____

Relationship to Subscriber: _____ Subscriber's Employer: _____

Insurance Group # _____ Insurance ID # _____

Tertiary Insurance Provider (if applicable): _____

Subscriber's Name (if different than patient): _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's SS#: _____-_____-_____

Relationship to Subscriber: _____ Subscriber's Employer: _____

Insurance Group # _____ Insurance ID # _____

WORKERS COMPENSATION or NO FAULT: **** Claim Number: _____

Insurance Company Name: _____ Phone: (_____) _____-_____

Street Address: _____ City, State, Zip: _____

Adj/Caseworker Name: _____ Adj Phone: (_____) _____-_____