Buffalo Niagara Physical Therapy
New Patient Intake

Date:_____

Name (Last) _____ (First)_____(MI)_____
Address_____
City_____State_____Zip code_____
Home phone ( )_____Work ( )_____ Cell ( )_____
E-mail:_____
Birthdate_____ SSN#_____

Emergency Contact name_____ Phone ( )_____

Circle one: Married (spouse name_____) Single Divorced Separated

Employer Name_____ Phone ( )_____
Address_____

Primary Insurance: please present card for photocopy
Insurance Carrier name_____ Start Date_____
Member No._____ Group No._____
Policy holder (if not same)_____ Birthdate_____

Secondary Insurance: (if applicable)
Insurance Carrier name_____ Start Date_____
Member No._____ Group No._____
Policy holder (if not same)_____ Birthdate_____

Workers Compensation : (if applicable)
Carrier name_____ Case no._____
Case Manager_____ Phone ( )_____

No Fault: (if applicable)
Carrier name_____ Case no._____
Case Manager_____ Phone ( )_____

This information has been completed accurately and to the best of my knowledge. I understand that I need to notify Buffalo Niagara Physical Therapy of any changes. I authorize Buffalo Niagara Physical Therapy to use this information for billing purposes.

Patient signature_____ Date_____