BUFFALO PHYSICAL THERAPY & SPORTS REHABILITATION, P.C.

		Rx Date	Diag code/Diagnosis	Referring MD
Patient Name	SS #	Age	Date of Birth	Male or Female
Street Address	City and State		Zip code	Home PH#
Patient's Employer	Occupation		Work Phone #	Emergency contact
Employers Street Address	City and State		Zip Code	Emergency contact #
Spouse or Parent name	Date of Birth		SS#	Ph#
Spouse or Parent s employer	Occupation		Ph #	
Employers Address	City and State		Zip Code	

REASON FOR VISIT

Date of injury	Area being treated
	Where did your injury occur? (location i.e., work, auto home)

Please check appropriate Insurance: Private(IHA,CB Univera, Medicare etc) Self Pay
Compensation No-Fault

PRIVATE INSURANCE Name		Policy#
COMPENSATION	Insurance Company	Date of Injury
WCB#	Address	Adjuster's Name
Case#	Phone #	Have you reported injury to employer ?
NO-FAULT	Insurance Company	Date of Accident
Policy holder	Policy #	Case #
Insurance Phone #	Address	Have you filed claim with Insurance Co ?

Attorney Name Address Phone #

PRECAUTIONS: Please check what applies
__ Heart Disease __ Implants/Pacemaker __ Diabetes __ High Blood Pressure
__Pregnancy __ Asthma __Cancer __Other

Insurance Information and Assignment

I hereby authorize Buffalo Physical Therapy & Sports Rehabilitation, P.C, to furnish information, to insurance carriers concerning my illness and treatments and hereby assign to Buffalo Physical Therapy & Sports Rehabilitation, P.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date_____ Signature_____

How did you hear about us?