Central Jersey Physical Therapy

14 Woodward Drive, Suite B, Old Bridge, NJ 08857 ■ Phone: 732 360 1100

Patient Information			
Patient Name: (First, MI, Last, - Sr., Jr., etc.)			Date of Birth (mm-dd-yyyy)
Address:	City	State:	Zip Code:
Telephone:	Cell/Mobile Telephone:	Sex: ☐ M ☐ F	Email (will not be shared)
Date of Injury / Onset Date / Surgery Date	Auto Related: ☐ Yes - State? _____ ☐ No	Work Related: ☐ Yes ☐ No	**Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Primary Insurance Information		
Policy Holder Name:	**Policy Holder Date of Birth:**	**Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

PLEASE PROVIDE YOUR INSURANCE CARDS AND DRIVERS'S LICENSE TO SCAN/COPY

Secondary Insurance Information		
Policy Holder Name:	**Date of Birth:**	**Patient Relationship to Policy Holder:** ☐ **Self** ☐ **Spouse** ☐ **Dependent** ☐ **Other**

Employer Information			
Employer Name:	Employer Phone #:	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student	
Address:	City	State:	Zip Code:

Emergency Contact Information		
Contact Name:	Phone #	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

I _____authorize **Central Jersey Physical Therapy Associates** to treat me as per my plan of care 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 claims for benefits. To the best of my knowledge, the above information is complete and correct. I understand my responsibility to inform my therapist of any change in information I.E., health, new injury, falls, insurance, address, or phone. The staff has explained my health benefits to me and I am aware that I am responsible for any costs not covered by my insurance.

Signature: _____ Date: _____