Rye PHYSICAL THERAPY & REHABILITATION P&R hands on experience

**This form can be completed on your computer, or printed and fill in by hand.**

## PATIENT INITIAL QUESTIONNAIRE

Date: _____

Last Name: _____ First Name: _____ Gender: ____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: (____)_____ Business Phone: (____)_____ Cell #: (____)_____

E-Mail Address: _____ Date of Birth: _____ SS#:_____

Marital Status: _____ Spouse's Name: _____

---

Employer: _____ Occupation: _____

Employer Address: _____ City:_____ State: _____ Zip: _____

---

**Primary Insurance Co.:** _____ Policy #: _____

Group #: _____ Policy Holder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to Policy Holder: _____

**Secondary Insurance Co.:** _____ Policy #: _____

Group #: _____ Policy Holder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to Policy Holder: _____

---

Person to contact in case of emergency: _____ Telephone: (____)_____

Relationship: _____

---

Are you a Workers' Compensation or No-Fault Case? Please Check One: ☐ YES ☐ NO

If Yes, Attorney's Name: _____ Phone #:_____

Have you been treated by any other Physical Therapy Facility? Please Check One: ☐ YES ☐ NO

If yes, approximately when: _____

---

I authorize the release of any medical information pertinent to my examination or treatment. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the information above and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient's Signature (Parent if Minor): _____ Dated: _____

**Please print this form, then sign in the space above.**