PATIENT INTAKE INFORMATION

Patient Information

Last Name	First	MI	Date of Birth	Age

Home Address	City	State	zip code

SS#	Home Phone	Work Phone	Cell Phone	Sex M F

email	Employer

Emergency Contact / Guardian / Insured Information

Last Name	First	MI	Home Phone	

Address	City	State	zip code

Referring Physician Information

Physician Last Name	First	UPIN#	

Address	City	State	zip code

phone	Fax	

Primary Insurance Information

Primary Insurance Company Name	Identification Number	Group #

Effective Date	Policy Holder (if other than patient)	Relationship

Secondary Insurance Information

Secondary Insurance Company Name	Identification Number	Group #

Effective Date	Policy Holder (if other than patient)	Relationship

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize First Step PT of LI or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

Please indicate primary insurance : • MEDICARE • HIP • BLUE CROSS • OXFORD • UHC
• NYS HIP (MPN) • WORKERS COMP NO FAULT • MEDICAID • Other