JERSEY CENTRAL PHYSICAL THERAPY PATIENT HISTORY

2147 Route 27
Edison NJ 08817

PLEASE PRINT

NAME	MARITAL STATUS S M W D SEP		HOME PHONE	
STREET ADDRESS	SOCIAL SECURITY #		DATE OF BIRTH	AGE
CITY	STATE	ZIP	EMAIL ADDRESS	
YOUR EMPLOYER/PHONE NUMBER	OCCUPATION		CELL PHONE NUMBER	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP	HOW LONG EMPLOYED	
NAME OF SPOUSE OR PARENT	SOCIAL SECURITY #		DATE OF BIRTH	AGE
EMPLOYED BY	OCCUPATION		WORK PHONE	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP	HOW LONG EMPLOYED	
REFERRING DOCTOR	ADDRESS		PHONE	
PRIMARY CARE PHYSICIAN	ADDRESS		PHONE	
DATE OF INJURY OR ONSET OF PAIN	LOCATION OF PAIN OR INJURY			

HEALTH INSURANCE INFORMATION

PATIENT OR INSURED NAME		SOCIAL SECURITY # OF INSURED PERSON	
HEALTH INSURANCE COMPANY NAME AND ADDRESS			
IDENTIFICATION #	DATE OF BIRTH	GROUP NUMBER	EFFECTIVE DATE OF POLICY

SECONDARY INSURANCE INFORMATION

PATIENT OR INSURED NAME		SOCIAL SECURITY # OF INSURED PERSON	
HEALTH INSURANCE COMPANY NAME AND ADDRESS			
IDENTIFICATION #	DATE OF BIRTH	GROUP NUMBER	EFFECTIVE DATE OF POLICY

MEDICARE AND PRIVATE PATIENTS:
I HEREBY AUTHORIZE JERSEY CENTRAL PHYSICAL THERAPY TO ADMINISTER TREATMENT TO MYSELF/MY DEPENDENTS, AND TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY/ MY DEPENDENCE'S ILLNESS AND TREATMENT. I HEREBY ASSIGN TO JERSEY CENTRAL PHYSICAL THERAPY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF/MY DEPENDENTS. SHOULD ENFORCMENT BE NECESSARY FOR COLLECTION OF MY BILL, I ACCCEPT REPSONSIBLITY FOR ALL ATTORNEY AND COLLECTION FEES AS WELL AS INTEREST CHARGES. I UNDERSTAND THESE FEES WILL EXCEED 50% OF MY OUTSTANDING DEBT. I UNDERSTAND THAT I MUST MAKE FULL PAYMENT ON ANY OUTSTANDING DEBTS WITHIN 30 DAYS AFTER INSURACNCE PAYMENT. I UNDERSATND I WILL BE RESPONSIBLE FOR A $25 CHARGE FOR ANY NO-SHOW VISITS OR APPOINTMENT CANCELLATIONS LESS THAN 24 HRS NOTICE.

MEDICARE AND PRIVATE PATIENTS:
I AM AWARE OF MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE, COINSURANCE OR COPAYMENT OF THE AMOUNT APPROVED BY MY INSURANCE COMPANY IF I HAVE NO SECONDARY INSURANCE. I AUTHORIZE JERSEY CENTRAL PHYSICAL THERAPY TO BILL MY INSURANCE FOR MY TREATMENT.

PATIENT OR GUARDIAN SIGNATURE: _____ DATE:_____