Finger Lakes Physical Therapy P.C.

Patient Information

Name (F,M,L,):_____Date of Birth:_____Student: **No**/**Yes** Full/Part Time
Nickname:_____Sex: Male/Female Employer:_____

Mailing Address: City: State: Zip Code:	Home #: ☐ Cell #: ☐ Work#: ☐ **(Check box for your preferred contact #)**
Social Security #:	E-mail:
Would you be willing to fill out our 10 question survey?	**No** or **Yes** **Paper** or **Email**
Primary Care Physician:	Referring Physician:
Insurance(s): 1st: 2nd:	Insurance ID #: 1st: 2nd: Group #:1st: 2nd:
Subscriber/Guarantor (F,M,L): **(if OTHER than yourself continue on)**	Relationship: Circle one: **Subscriber Guarantor Both**
Their Date of Birth:	**Their** Social Security #:
Their Address **(If DIFFERENT than yours)**: Street: City: State: Zip:	**Their** Home #: Cell #: E-mail:
No Fault Auto Insurance	Date of Injury:
Insurance Carrier: Address: City: State: Zip:	Claim #: Claim Adjuster: Phone #:
Workers Compensation	Date of Injury:
Insurance Carrier: Address: City: State: Zip:	Claim #: Case Worker: Phone #:
Employer: Phone #:	Address: City: State: Zip: