Southern Tier Physical Therapy of Binghamton, P.C.

Patient Information Form

Contact Information

Patient Name _____
Patient Address _____
Patient City _____
Patient State _____
Patient Zip _____
Patient Phone, Home. (_____) _____ - _____
Patient Phone, Cell (_____) _____ - _____
Patient Phone, Work (_____) _____ - _____
Patient Email _____
Best way to remind you about appointment
Text-Cell _____ Call-Cell _____ Call-Home _____
Emergency Contact _____
Relation to Patient. _____
Emergency Phone . (_____) _____ - _____
Patient Gender _____
Marital Status_____
Student? _____
SSN _____
Date of Birth _____

Injury Details

Body Part_____
Injury Onset Date_____
Is condition related to Workers Comp/Auto. ___(Y/N)
Surgery Date _____

Referral Source

Referring MD _____
Referring Phone(_____) _____ - _____
PCP Name _____

Primary Ins. Or Workers Comp or Auto

Insurance _____
ID# / Claim #_____
Phone (_____) _____ - _____
Group# _____
Case Worker_____
Caseworker Phone (_____) _____ - _____
Employer_____

Insurance Subscriber

Name _____
Date of Birth _____
Gender _____
Relationship to Patient_____

Secondary Insurance

Insurance _____
ID# / Claim # _____
Phone (_____) _____ - _____
Group# _____
Case Worker _____
Caseworker Phone (_____) _____ - _____
Employer _____

Insurance Subscriber

Name _____
Date of Birth _____
Gender _____
Relationship to Patient. _____

Third Insurance

Insurance _____
ID# / Claim# _____
Phone (_____) _____ - _____
Case Worker _____
Caseworker Phone (_____) _____ - _____
Employer _____

* Have you previously had physical therapy? _____. If yes, what for? _____. And where and when? _____

** If you want someone besides yourself to be able to access your medical information and/or billing please talk to the receptionist.