GOUVERNEUR PHYSICAL THERAPY, PLLC

NEW PATIENT INFORMATION SHEET Allergies_____

Name_____Home Phone_____Mobile Phone_____
Address_____City_____State_____Zip_____
E-mail address_____Occupation_____
Date of Birth_____Social Security Number_____Marital Status_____
Place of Employment_____Work Phone_____
In case of emergency contact_____Phone Number_____
Address_____Relationship_____
Second emergency contact_____Phone Number_____Relationship_____
Referring Physician_____Family Physician_____

- **GENERAL INSURANCE INFORMATION**

Primary Insurance_____ Secondary Insurance_____
Subscriber's Name_____ Subscriber's Name_____
Subscriber's Date of Birth_____ Subscriber's Date of Birth_____
Certificate or ID#_____ Certificate or ID#_____
Group or Access #_____ Group or Access #_____
Authorization # (When Applicable)_____ Authorization # (When Applicable)_____

- **NO-FAULT INSURANCE INFORMATION**

Insurance Company Name_____Phone Number_____
Address_____City_____State_____Zip_____
Policy #_____Claim/File #_____Date of Injury_____
Insured's Name_____ Was a motorcycle or DUI involved? _____ Yes _____ No

- **WORKERS' COMPENSATION INSURANCE INFORMATION**

Employer_____Work Phone_____
Address_____City_____State_____Zip_____
Insurance Carrier Name_____Phone Number_____
Address_____City_____State_____Zip_____
WCB#_____Carrier Case #_____Date of Injury_____
Insurance Adjuster_____Are you currently working? _____ Yes _____ No
Address where injury occurred_____

I hereby certify that the information above is, to the best of my knowledge, complete and accurate. I understand that I am financially responsible to Gouverneur Physical Therapy, PLLC for all therapy services rendered at this clinic whether or not covered by insurance. I also hereby authorize release of information pertaining to my medical condition and therapy treatment to my insurance company, Social Security Administration, or Medicare program.

SIGNATURE_____

STATEMENT TO AUTHORIZE PAYMENT OF BENEFITS

I certify that the information given by me in applying for payment is correct. I authorize Gouverneur Physical Therapy, PLLC to release any medical information required to process my claim. I request that payment be made to Gouverneur Physical Theray, PLLC for services provided to me.

SIGNATURE_____DATE_____