Kinnelon Physical Therapy

17 Kiel Avenue
Kinnelon, NJ. 07405
Tel: (973) 838 – 3733
Fax: (973) 492-5822

Daniel S. Myers, P.T. Cathy DeStefano P.T.

PATIENT INFORMATION FORM

PATIENT NAME: _____ AGE: _____ BIRTHDATE: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

EMAIL ADDRESS: _____ HOME PHONE: _____
(Will be used by Kinnelon Physical Therapy only)

CELL PHONE: _____ BUSINESS PHONE : _____

EMPLOYMENT STATUS: FT __ PT __ SELF EMPLOYED __ RETIRED __ STUDENT __ NOT EMPLOYED __

EMPLOYER : _____

BUSINESS ADDRESS: _____

SSN OF PARENT IF PATIENT IS A MINOR: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

NAME: _____ RELATIONSHIP: _____

PHONE: _____

CONSENT FOR TREATMENT: I HEREBY AUTHORIZE KINNELON PHYSICAL THERAPY AND ITS APPROPRIATE PERSONNEL, TO PERFORM OR HAVE PERFORMED UPON ME,

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OR THE ABOVE NAMED PATIENT I AUTHORIZE, APPROPRIATE EVALUATION AND TREATMENT.

[X] I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM(S).

[X] I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO KINNELON PHYSICAL THERAPY, INC.

DATE: / / /

SIGNATURE OF PATIENT OR LEGAL GUARDIAN/PARENT IF PATIENT IS A MINOR