240 Red Tail Dr.
Suite 3 & 4
Orchard Park, NY 14127
Phone: 716-674-9600
Fax: 716-674-9700

4535 Southwestern Blvd
Suite 805 & 806
Hamburg, NY 14075
Phone: 716-648-8700
Fax: 716-648-0400

Patient information Sheet

Name: _____
Address: _____
City: _____ State: _____ Zip Code:_____
Home Phone #: (_____)_____ Cell Phone #: (_____)_____

Social Security #: _____-_____-_____ Email _____
Date of Birth: _____/_____/_____

Occupation: _____
Employer: _____
Address: _____
_____
Employer Phone #: (_____)_____

Current Work Status: (*Please check one*)

___Full-Time
___Part-Time
___Retired
___Homemaker
___Student
___Full-Time with Restrictions
___Part-Time with Restrictions
___Part. or Perm. Disabled
___Currently out of work due to injury
___Unemployed

Current Marital Status: (*Please check one*)

___Single
___Married
___Widowed
___Divorced
___Separated

Primary Care Physician: _____
Referring Physician: _____

Name of person that we can contact in case of emergency: _____
Phone #: _____

Primary Health Insurance:

Name: _____
Address: _____
_____
Phone #: (_____)_____

Insurance ID#: _____
Group#: _____

Policyholder Name: _____
Relationship to the patient: _____
Policyholder Social Security #: _____-_____-_____
Policyholder Date of Birth: _____/_____/_____

ProActive Sports Rehab

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Secondary Health Insurance (if Applicable)

Name: _____
Address: _____
_____
Phone #: (_____)_____

Insurance ID#: _____
Group#: _____

Policyholder Name: _____
Relationship to the patient: _____
Policyholder Social Security #: _____-_____-_____
Policyholder Date of Birth: _____/_____/_____

1. Have you been treated for physical therapy in this current year? **YES** / **NO**
   If yes please state date and number of visits: _____

2. Is this a work related injury? **YES** / **NO**
   If yes please state date: _____

3. Is this injury a result of a motor vehicle accident? **YES** / **NO**
   If yes please state date: _____

A copy of the **Notice of Privacy Practices** is posted in each clinic and is available upon request. HIPAA CONTACT: Jeff Kirchmyer at (716) 674-9600 or Anthony Goode at (716) 648-8700

All information provided on this form is complete and accurate to the best of my knowledge. No fraudulent information has been provided. I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

If there are any individuals or organizations that you would like to review your medical information, please list them: _____
_____

Patient Signature: _____ **Date:** _____

Printed name: _____

If you are a guardian or personal representative of the patient, describe your relationship to patient.

Printed name: _____ Date: _____

Signature: _____

Relationship to the patient: _____