BUFFALO PHYSICAL THERAPY
& SPORTS REHABILITATION, P.C.

Patient Name	SS #	Age	Date of Birth	Home PH #
Street Address	City and State		Zip code	Cell PH #
Patients/Parents Email Address			Spouce/Parent Name	Cell PH #
Patient's Employer	Occupation		Work PH #	Emergency contact #
Employers Street Address	City/State/Zip Code			

REASON FOR VISIT

Date of injury	Area being treated
Where did your injury occur? (Home, Work, Auto)	Where did you hear about us?

COMPENSATION	Insurance Company	Date of Injury
WCB #	Address	Adjuster's Name
Case #	Phone #	Have you reported injury to employer ?

NO-FAULT	Insurance Company	Date of Accident
Policy holder	Policy #	Case #
Insurance Phone #	Address	Have you filed claim with Insurance Co ?

Attorney Name	Address	Phone #

IF YOU ARE A MEDICARE PATIENT-ARE YOU CURRENTLY RECEIVING ANY HOME CARE SERVICES? YES _____ NO _____

Insurance Information and Assignment

I hereby authorize Buffalo Physical Therapy & Sports Rehabilitation, P.C. to furnish information to insurance carriers concerning my illness and treatments and hereby assign to Buffalo Physical Therapy & Sports Rehabilitation, P.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount NOT covered by insurance.

Date__________ Signature___________________________