Dx Code:_____

PATIENT INFORMATION

FIRST NAME:_____MI:_____LAST NAME:_____
ADDRESS:_____CITY:_____STATE:_____ZIP:_____
HOME PHONE:_____WORK PHONE:_____ CELL PHONE:_____
SS#:_____-_____-_____BIRTHDATE:_____/_____/_____ SEX (circle): Male or Female
DATE OF ACCIDENT/ INJURY:_____
EMPLOYER:_____
EMPLOYER ADDRESS:_____CITY:_____ZIP:_____
NAME/PHONE # OF PERSON TO CONTACT IN EMERGENCY:_____
E-MAIL ADDRESS:_____*(By providing your e-mail address you authorize Buffalo Rehab Group to send you information via e-mail)
NAME OF PRIMARY CARE PHYSICIAN:_____

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY NAME:_____
NAME OF PERSON INSURED:_____INSURED SS#:_____/_____/_____
BIRTHDATE OF PERSON INSURED:____/____/____ WERE YOU PREVIOUSLY UNDER THE CARE OF ANOTHER PHYSICAL THERAPIST THIS YEAR? NO YES-IF YES, PLEASE GIVE NAME/ADDRESS/DATES:_____

WORKERS COMPENSATION

INSURANCE COMPANY NAME:_____
INSURANCE COMPANY ADDRESS:_____CITY:_____
STATE:_____ ZIP CODE:_____CARRIER CASE/CLAIM #:_____WCB#:_____
I refuse to provide Buffalo Rehab Group with my personal health insurance information. I am aware that if Workers Compensation denies payment, I am solely responsible for the remainder of the bill. Initials _____

NO FAULT

INSURANCE COMPANY NAME:_____
INSURANCE COMPANY ADDRESS:_____CITY:_____
STATE:_____ZIP CODE:_____ CLAIM#:_____POLICY#:_____
POLICY HOLDER NAME:_____
I refuse to provide Buffalo Rehab Group with my personal health insurance information. I am aware that if No Fault denies payment, I am solely responsible for the remainder of the bill. Initials _____

PLEASE READ AND SIGN BELOW

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies of their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I agree to be responsible for all collections or attorneys fees, should this account become past due. I permit a copy of this release to be used in place of the original.

PATIENT SIGNATURE (GUARDIAN IF UNDER AGE 18)_____DATE____/____/____

2100 Union Rd
West Seneca, NY 14224
Phone: 716 656-8600
Fax: 716 656-1560

8750 Transit Rd
Amherst, NY 14051
Phone: 716 568-1251
Fax: 716 568-1253

4780 S. Park Ave
Hamburg NY, 14075
Phone: 716 646-9100
Fax: 716 646-9744

350 Greenhaven Terrace
Tonawanda NY, 14150
Phone: 716 213-0772
Fax: 716 213-0773

4855 Camp Road
Hamburg NY, 14075
Phone: 716 646-1100
Fax: 716 646-1106