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:__________________________________
NAME OF PRIMARY CARE PHYSICIAN:____

E-MAIL ADDRESS:____________________________________*(By providing your e-mail address you authorize Buffalo Rehab Group to send you information via e-mail)

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY NAME:____
NAME OF **SUBSCRIBER**:__________________________ **SUBSCRIBER SS#**:_________/______/________
BIRTHDATE OF **SUBSCRIBER**:____/____/____

*****WERE YOU PREVIOUSLY UNDER THE CARE OF ANOTHER PHYSICAL THERAPIST FOR THIS CONDITION 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	8750 Transit Rd	4780 S. Park Ave	350 Greenhaven Terrace	4855 Camp Road
West Seneca, NY 14224	**Amherst**, NY 14051	**Hamburg** NY, 14075	**Tonawanda** NY, 14150	**Hamburg** NY, 14075
Phone: 716 656-8600	Phone: 716 568-1251	Phone: 716 646-9100	Phone: 716 213-0772	Phone: 716 646-1100
Fax: 716 656-1560	Fax: 716 568-1253	Fax: 716 646-9744	Fax: 716 213-0773	Fax: 716 646-1106