

**JERSEY CENTRAL PHYSICAL THERAPY PATIENT HISTORY**

**2147 Route 27  
Edison NJ 08817**

**PLEASE PRINT**

NAME	MARITAL STATUS S M W D SEP		HOME PHONE	
STREET ADDRESS	SOCIAL SECURITY #		DATE OF BIRTH	AGE
CITY	STATE	ZIP	EMAIL ADDRESS	
YOUR EMPLOYER/PHONE NUMBER	OCCUPATION		CELL PHONE NUMBER	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP	HOW LONG EMPLOYED	
NAME OF SPOUSE OR PARENT	SOCIAL SECURITY #		DATE OF BIRTH	AGE
EMPLOYED BY	OCCUPATION		WORK PHONE	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP	HOW LONG EMPLOYED	
REFERRING DOCTOR	ADDRESS		PHONE	
PRIMARY CARE PHYSICIAN	ADDRESS		PHONE	
DATE OF INJURY OR ONSET OF PAIN	LOCATION OF PAIN OR INJURY			

**HEALTH INSURANCE INFORMATION**

PATIENT OR INSURED NAME		SOCIAL SECURITY # OF INSURED PERSON	
HEALTH INSURANCE COMPANY NAME AND ADDRESS			
IDENTIFICATION #	DATE OF BIRTH	GROUP NUMBER	EFFECTIVE DATE OF POLICY

**SECONDARY INSURANCE INFORMATION**

PATIENT OR INSURED NAME		SOCIAL SECURITY # OF INSURED PERSON	
HEALTH INSURANCE COMPANY NAME AND ADDRESS			
IDENTIFICATION #	DATE OF BIRTH	GROUP NUMBER	EFFECTIVE DATE OF POLICY

**MEDICARE AND PRIVATE PATIENTS:**

I HEREBY AUTHORIZE JERSEY CENTRAL PHYSICAL THERAPY TO ADMINISTER TREATMENT TO MYSELF OR MY DEPENDENTS, AND TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY (OR MY DEPENDENCE'S) ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO JERSEY CENTRAL PHYSICAL THERAPY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. SHOULD ENFORCMENT BE NECESSARY FOR COLLECTION OF THE BILL, ATTORNEY AND COLLECTION FEES AS WELL AS INTEREST CHARGES WILL BE MY RESPONSIBLTIY. I UNDERSTAND THAT PAYMENT FOR SERVICES RENDERED IS DUE IN 30 DAYS AFTER INSURACNCE PAYMENT.

**MEDICARE AND PRIVATE PATIENTS:**

I AM AWARE OF MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE, COINSURANCE OR COPAYMENT OF THE AMOUNT APPROVED BY MY INSURANCE COMPANY IF I HAVE NO SECONDARY INSURANCE. I AUTHORIZE JERSEY CENTRAL PHYSICAL THERAPY TO BILL MY INSURANCE FOR MY TREATMENT.

PATIENT OR GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_