Rehabilitation Physical Therapy
Relieving pain. Restoring lives. One patient at a time.

1578 Williamsbridge Rd. Suite 3D
Bronx, NY 10461
Phone: (718) 863-DAZA (3292)
Fax: (718) 863-3290
Web: www.DazaPhysicalTherapy.com

PATIENT INFORMATION

Date _____ Home Phone (____)_____ Cell (____)_____

Name_____ SS/HIC/Patient ID# _____
Last Name First Name Middle Initial

Address _____
Apt# City State Zip

Sex: ❑ M ❑ F Age: _____ Birth date: _____
❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced

Patient Employer/School _____ Occupation _____
Employer/School Address _____
Employer/ Phone (____)_____ **Referred by** _____
In case of emergency who should be notified? _____ Phone (_____)_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to patient _____ Birth date _____ Soc. Sec.# _____
Address (if different from Patient's) _____ Phone (___)_____
City_____ State _____ Zip _____
Relation to patient _____

SECONDARY INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No
Person responsible for 2nd Insurance _____ Birth date _____
Relation to patient _____
Soc. Sec. # _____ Phone (___)_____ Group# _____
Policy# _____ Names of other dependents covered under this plan _____
_____

ALLERGIES: _____ **ASTHMA:** ❑ Yes ❑ No

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ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Diana Daza PT . _____all insurance benefits, if any, otherwise payable to Rehabilitation Physical Therapy Services P.C for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance including deductibles and co-insurances (20% balances of Medicare payments). I authorize to use of my signature on all insurance submissions. The above name physical therapist may use my health care information and may disclose such information to the above name insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of patient, parent, guardian or personal representative Date

_____ _____
Print name of patient, parent, guardian or personal representative Date