Spectrum Physical Therapy & Athletic Training

Patient Information

Patient Name:____ Date of Birth:____________________

Address:____ Email ___________________________

____

Telephone: Home______________________Cell:____________________Work:_____________________

Physician Information

Referring Doctor:____

Date of Prescription:___________________ Injury/Condition:_________________________________

*Please be aware, NJ State regulations require a Doctor's Prescription after 30 days. If you are visiting us without a Doctor's prescription you will be responsible for getting a prescription after 30 days.

Condition/Injury

Condition/Injury:___________________________ Date of Surgery:______________________________

Medicare:____ Are you currently receiving HOME HEALTH CARE Services?_______________________

Date of Accident/Injury:_____________

Auto:_____ State:_____ School/Sports:___________ High School: ___________________________

Workers Comp:____ State:_______ Employer:____

Employer Address:____

Insurance

Primary Insurance:____________________________ Secondary Insurance:______________________

Insured:_____________________________________ Date of Birth:______________________________

I ________________________________authorize Spectrum Physical Therapy & Athletic Training LLC to treat me as per my doctor's prescription and to release to my insurance company/attorney/employer any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation of claims for benefits.

Signature:____Date:____________________________

Guardian Signature:____