DREAM
PHYSICAL THERAPY
FEELS LIKE A DREAM
ONLY WITH REAL RESULTS

PATIENT REGISTRATION FORM

Dream Physical Therapy
43-34 32nd Place, Penthouse
Long Island City, New York 11101
212-500-0560

1. Personal Info

Todays Date:

First Name _____ Last Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ State _____ ZIP _____

Phone # _____ Email Address _____

Emergency Contact Person _____ Phone # _____ (if minor) Parent/Guardian Name and Signature _____

Occupation _____ Employer Name _____ Phone # _____

- My condition is related to: ❑ Work ❑ Auto Accident (State _____) ❑ Other _____

Social Security # _____ Date of Birth _____/_____/_____ ❑ Single ❑ Married

2. Referral Info

How did you hear about us? _____

Primary or Referring Physician Name (If Applicable) _____

Street Address _____

City _____ State _____ Zip _____

Phone _____

Do you have a followup appointment with this physician? _____

If yes, when? _____

3. Insurance Info

Patient Name _____ DOB _____

Insurance Provider _____

Insurance Phone # for Providers _____

ID # _____

Insurance Policy # _____ Group # _____

Insured Name (if other than patient) _____ Insured DOB _____

Your relationship with the Insured:

❑ Parent ❑ Spouse ❑ Other: _____

4. Credit Card on File

__Visa __MC __AmerX __Discover Card # _____

Name on Card _____ Exp Date _____ CVV code _____

Cardholder Signature _____