



KEN-TON PHYSICAL THERAPY  
 2438 ELMWOOD AVE, KENMORE NY 14217  
 PHONE (716) 873-9154 FAX (716) 875-3796

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Parent or Guardian if a minor: \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_ e-mail \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F Marital Status: Single / Married / Partnered / Divorced / Widowed / Separated

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employers address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work/Cell) \_\_\_\_\_

\*\*\*\*\*Have you had therapy at this or any other facility this year? Yes No

**PRIMARY INSURANCE INFORMATION**

(For Work Comp and No Fault see below, please supply us with your health insurance information also)

Circle One: BC/BS WNY Community Blue IHA Univera Medicare Other \_\_\_\_\_

ID#: \_\_\_\_\_ Plan# \_\_\_\_\_ Group#: \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Co-pay required: Yes / No / Uncertain

**SECONDARY INSURANCE INFORMATION**

Insurance Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Plan# \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Co-pay Required Yes / No / Uncertain

**WORK COMP / NO FAULT INFORMATION**

Date of Injury/Accident: \_\_\_\_\_ Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

No Fault Policy# \_\_\_\_\_ Claim / Carrier Case#: \_\_\_\_\_

Claim Representative/Adjustor: \_\_\_\_\_ WCB Claim# \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT:**

I HEREBY AUTHORIZE KEN-TON PHYSICAL THERAPY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO KEN-TON PHYSICAL THERAPY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

\*\*\* OUR OFFICE RESERVES THE RIGHT TO DISCHARGE PATIENTS AFTER (3) NO SHOWS.

DO YOU HAVE ANY LAWSUITS OR LITIGATION FOR THIS INJURY IN PROGRESS YES NO

HOW DID YOU FIND OUT ABOUT US? FRIENDS/FAMILY PHONE BOOK PHYSICIAN OTHER

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_