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 _____

Preferred Name/ Nick Name _____ Preferred Pronouns_____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____(Cell) _____ e-mail_____

SS# _____-_____-_____ Sex: M F O 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:_____