CT PHYSICAL THERAPY CARE P.C.

43-41 52nd St, Woodside, NY 11377-4543
T: 718-2556229; F: 718-2551288
www.ctphysicaltherapycare.com

PATIENT INFORMATION

Last Name: ________________________ First Name: _________________ Middle Name: _________

Date of Birth: _________________ Gender: ____F ____M Social Security: _________________

Email: _____________________ Tel. #: _____________________ Cell #: _____________________

Would you like to receive email, voice, or text communications? ____Yes ____No

Address: ____

Marital Status: ____Single ____Married ____Widow/Widower ____ Divorced

Emergency Contact Name: _________________ Contact No: _____________ Relation: _________

INSURANCE INFORMATION

Primary Insurance: _____________________ Member ID: _________________ Co Pay: _________

Relation to the Insured: ________ Name of Primary Holder: _________________ DOB: _________

Primary Insurance: _____________________ Member ID: _________________ Co Pay: _________

Relation to the Insured: ________ Name of Primary Holder: _________________ DOB: _________

MEDICAL HISTORY

____Hypertension
____Diabetes
____Hypercholesterol
____Asthma
____COPD
____Hypothyroidsm
____Hyperthyroidsm
____Osteoporosis

MEDICATIONS: ____________________________________
____
____
____

ALLERGIES: ____________________________________
____

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____Heart Disease HOSPITALIZATIONS:

____

____Lung Disease

____

____Kidney Disease SURGICAL HISTORY:

____

____Other

____

BP:_________ HR:_________ RR:_________ Ht:_________ Wt:_________

Primary Doctor: ____ Tel. No.: ________________________

Address: ____ Fax No.: ________________________

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Signature: ____ Date: ________________________