CT Physical Therapy Care
4341 52nd St; Woodside NY 11377
T: 718-2556229   F: 7182551288

PATIENT INFORMATION

Last Name: ________________________ First Name: ____________________ Middle Initial: _____

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: ____________________ Tel No: ______________ Relation: _____________ ________

INSURANCE INFORMATION

Primary Insurance: _______________________ Member ID: ___________________ Co Pay: $______

Relation to Insured: __________ Name of Primary Holder: ____________________ DOB:___/___/___

Secondary Insurance: _________________________ Member ID: _______________ Co Pay: $______ __________

MEDICAL HISTORY

_____Hypertension.
_____Diabetes
_____Hyper cholesterol
_____Asthma
_____COPD
_____Hypothyroidism
_____Hyperthyroidism
_____Osteoporosis
_____Heart Disease
_____Lung Disease
_____Kidney Disease
_____Other ____________________

MEDICATIONS: ______________________________________
____
____
____

ALLERGIES: ______________________________________
____

HOSPITALIZATIONS: ______________________________
____

SURGICAL HISTORY: ______________________________
____

BP: _____/_____ HR:__________ RR: __________ Ht: __________ Wt: __________

Primary Doctor: ____ Tel: _____________________
Address: ____ Fax: _____________________