Physical Therapy & Hand Therapy
420 Lexington Ave., Suite 1714
New York, NY 10170
Tel: 212-697-3438 Fax: 212-697-5983
Grandcentralpt.net

New Patient Registration

Patient's Name: ____
Last Name First Name Initial

Home Phone:_______________Cell Phone:_________________email address:_____________________

Address:____

City:____State__________Zip code:_________________

SS#______________________ Sex: ________ Age: ________ Date of Birth: ___________________

Single ________ Married _______ Separated _____ Divorced ______

Patient's employer: ____ Occupation: ______________

Business address: _____________________________________ Business phone: _________________

How did you hear of Grand Central Physical Therapy & Hand Therapy? Please check all that apply:

Friend ______________ Physician____________ Internet Search _____________ Other______________

Referring MD____

Who should be notified in case of emergency?____

Phone number: ___________________________ Relationship to patient ______________________

Is your diagnosis due to a work or automobile-related accident? Yes__________ No___________
Is there litigation involved? Yes__________ No___________

Insurance Information

Person responsible for account: ____
Last name First name Relationship to patient:

If the person responsible for the insurance account is someone other than the patient, fill out the following:

Address: ______________________________________ City:_____________________State_________

Zip code:____________ Phone_____________________Employer:____________________________

Employer's address:____

Business phone: __________________________

Insurance company name/address: ____

Policy #: ___________________ Group #:____________ SS# of person responsible __________________

Please fill out and sign the following release authorization so that we can process your insurance forms.

I, the undersigned, certify that I or my dependent have insurance coverage with
(name of insurance company) ____.

I understand that I am financially responsible for all charges, whether or not paid by my insurance. I herby authorize the use of this signature on all insurance submissions.

Signature: ________________________________ Date: ______________________