

190 Union Avenue
Brooklyn, N.Y. 1121
Phone: (718) 387-7420



Web: Bbwphysicaltherapy.com
Email: BbodyworksPT@aol.com
Fax: (718) 387-7421

Brooklyn Bodyworks Physical Therapy, P.C. Intake Form

Patient Information

Social Security # _____ - _____ - _____

Patient Name:

(Last) (First) (Middle)

Address: _____ Apt.: _____ City: _____

State: _____ Zip: _____

Phone: Home () _____ - _____ Work () _____ - _____ Ext. _____

Cell () _____ - _____

Date of Birth: ____/____/____ Sex: M F

Marital Status: M S D W U

Email Address:

Employer Name and Address:

Responsible Party Information

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____

Name: _____

(Last) (First) (Middle)

Address: _____ Apt.: _____ City: _____

State: _____ Zip: _____

Phone: Home () _____ - _____ Work () _____ - _____ Ext. _____

Cell () _____ - _____

Social Security # _____ - _____ - _____ Date of Birth: ____/____/____

Insurance Information**Primary Insurance**

Carrier's Name: _____

Phone No. () _____ - _____

Address: _____ City: _____

State: _____ Zip: _____

Policy/I.D. #: _____ Group # _____

Group Name: _____

Authorization/Pre-Certification #: _____

Secondary Insurance

Carrier's Name: _____

Phone No. () _____ - _____

Address: _____ City: _____

State: _____ Zip: _____

Policy/I.D.: _____ Group # _____

Group Name: _____

Emergency Contact (List two people that we can contact)

Contact Name: _____ Relationship: _____

Phone: _____

Contact Name: _____ Relationship: _____

Phone: _____

Accident Information

Referring Physician: _____

Phone No.: () _____ - _____

Diagnosis: _____ Prescription date: ____/____/____

Therapist: _____

Workman's Compensation / No Fault (Please Circle One)

Date of Accident: ____/____/____ Policy/Claim ID: _____

Auth/Pre-Cert#: _____

Carrier's Name: _____

Phone No.: () _____ - _____

Address: _____ City: _____

State: _____ Zip: _____

Contact Person/Attorney Name: _____

Phone No.: () _____ - _____

Address: _____ City: _____

State: _____ Zip: _____

Payment Agreement: If for any reason my claim is denied and payment for physical therapy is stopped, I agree to pay in full any charges that are outstanding.

Signature: _____ Date: ____/____/____

