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DAVID GARBER, PT
Physical Therapist

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Patient Information Form
(Please Fill All Parts Which Are Applicable)

Date _____

Patient's Name _____ **Male/Female**

Address _____ **City** _____ **State** _____ **Zip** _____

Phone # _____ **Cell#** _____ **Soc Sec #** _____

Date of Birth _____ **Marital Status** _____

Email: _____

Date of Injury/Accident _____ **Explain** _____

Referring Physician _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Primary Care Physician _____

Phone # _____

Previous Condition(s) We Should Be Aware Of _____

Primary Insurance Name _____

Id # _____ **Group #** _____

Name of Insured (if different from patient) _____

Insured's Date of Birth _____ **Relationship** _____

Secondary Insurance: _____ **ID#** _____

Employer: _____

Address: _____

Work Tel # _____

Credit Card Information - REQUIRED

*Name on Credit Card:

(Your name as it appears on your credit card)

*Zip Code:

*Credit Card: Visa MasterCard American Express

*Card Number:

Expiration Date:

CREDIT CARD AUTHORIZATION FORM

As per The Health Information Privacy and Portability Act (HIPAA), the above information is strictly confidential.
I authorize Englewood Cliffs Physical Therapy and Sports Medicine to charge this credit card for any incurred balances.
I understand that ECPT will inform me prior to any charges applied to the credit card provided above.

CARD HOLDER SIGNATURE: _____