



NYU Physical Medicine and Rehabilitation Associates
 400 East 34th Street, RR228B, New York, NY 10016

Patient Information	Name (Last, First, MI)				Today's Date	
	Street Address					
	City	State	Zip	Age	Date of Birth	
	Social Security #	Daytime Phone ()		Evening Phone ()		
	Occupation	Employer	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
Emergency Contact	Name				Relationship to Patient	
	Daytime Phone ()			Evening Phone ()		
Referral Info	Referring Physician's Name (if applicable)			Physician Phone/Fax (if known) () /		
	Physician Address (if known)					
Insurance Information	Primary Insurance Company		Policy #	Group #		
	Claims Address	City	State	Zip	Phone	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
	Secondary Insurance Company		Policy #	Group #		
	Claims Address	City	State	Zip	Phone	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if Other Than Patient)		
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Assignment and Release	Please read the following and sign below					
	<u>Assignment of Benefits and Release of Information</u> I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.					
	<u>Medicare Patients</u> I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.					
	<u>Notice of Privacy Practices Acknowledgment</u> By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.					
	Signature: _____				Date: ____ / ____ / ____	



NYU School of Medicine NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Rusk Institute of Rehabilitation Medicine

Patient Name:

Date of birth:

Date:

Reason for visit/ current complaints:

Date of onset (approximately if not known): _____

Past medical history:

Past surgical history:

Recent hospitalizations (Hospital name and dates of admission and discharge):

Allergies (food and drug): _____

Medications (name, dose and directions):

Living situation/ disability:

Family history/ other relevant information:
