Coast PT
Cayuga Orthopaedic and Sports Physical Therapy

37 W Garden Street, Suite 103
Auburn, New York 13021-2663

t 315.253.3291
f 315.258.8759

Patient Information

Name _____ Date of birth _____ Gender Male Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Leave a message? Yes / No

Preferred contact number Cell Home Work Email Address _____

Permission to send electronic notifications/statements Yes No Preferred method Mail Text Email

Place of Employment _____ Work Number _____

Spouse (or Parent) Name _____ Phone Number _____

Spouse (or Parent) place of Employment _____ Work Number _____

Emergency Contact _____ Phone Number _____

Health insurance information:

Primary Care Physician _____ Referring physician _____

Primary Health Insurance _____

Subscriber Name _____ DOB _____

Subscriber ID _____ Group ID _____

Patient relationship to subscriber Self Spouse Child Other Subscriber Employer _____

Secondary Health Insurance (if any) _____

Subscriber Name _____ DOB _____

Subscriber ID _____ Group ID _____

***Date of onset/injury/surgery** _____

This injury is the result of: Work related Automobile accident Other

Health History: If you currently have or have a history of any of the following, please check those that apply:

- ❒ Diabetes
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Heart Disease/attack
- ❒ Pacemaker
- ❒ Headaches
- ❒ Kidney Problems
- ❒ Nervous Problems
- ❒ Hernia (type)
- ❒ Rheumatoid Arthritis
- ❒ Skin Sensitive to heat
- ❒ Skin Sensitive to cold
- ❒ Dizziness
- ❒ Cigarette Smoker
- ❒ Seizures
- ❒ Metal Implants
- ❒ Osteoporosis
- ❒ Pregnant
- ❒ Unexplained Weight Loss
- ❒ History of Cancer

Allergies: _____

Other Conditions: _____

Previous Injuries (dates) _____

Previous Surgeries (dates) _____

Please list any **medications** that you are taking and why you are taking it: (if you have a copy of your medications list, please provide)

I hereby authorize Cayuga Orthopaedic and Sports Physical Therapy, P.C. to furnish the insurance company with full information regarding my treatment when so requested. I understand I must sign a release if information is requested from a source not covered by the privacy policies.

Patient Signature: _____ Date: _____