ALLY Physical Therapy, LLC
2460 Lemoine Avenue Suite 204 Fort Lee, NJ 07024
Tel: 201-742-1114 | Fax: 201-482-8757

New Patient Intake Form

Date:_____

Personal Information

First Name: _____ M.I. _____ Last Name: _____

D.O.B. (MM/DD/YYYY): _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____Occupation: _____

Email Address: _____

Contact Preference for appointment reminders (circle one): Home Cell Email

By selecting a contact preference for appointment reminders only, you understand that texts or emails may not be secure.

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Is your designated personal representative* the same as your emergency contact? Yes No

If no, designated personal representative: _____ Phone: _____

**A person that can communicate on a patient's behalf regarding treatment, insurance verification, authorization, referral and insurance payment or denial.*

Insurance Information

Subscriber's Name: _____ D.O.B. (MM/DD/YYYY) _____

Patient Relationship to Subscriber: _____

Primary Insurance: _____

Member/Insurance ID #: _____ Group #: _____

Primary Insurance Phone Number: _____

Copay: _____ Maximum annual benefit: _____

Deductible: _____

Secondary Insurance: _____

Member/Insurance ID #: _____ Group #: _____

Secondary Insurance Phone Number: _____

Is this MVA (Motor Vehicle Accident) or Workman's Comp? Yes / No Claim Number: _____
Claim Adjuster's Phone Number: _____ Date of Occurrence: _____

For Medicare Patients Only:
Have you gone to Physical Therapy this calendar year? Yes / No
Have you had or currently having home health services this calendar year? Yes / No

Primary Care Physician: _____ Phone Number: _____
Referring Physician: _____ Phone Number: _____

How did you hear about us? _____