DYNAMIC SPORTS PHYSICAL THERAPY
8 West 36th Street, 5th floor
New York, NY 10018

New Patient Registration & Personal Information:

Last Name/First Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

E-mail: _____ Referring Physician: _____

Social Security: _____ Marital Status: _____ Married _____ Single

Sex: ____ Male ____ Female Date of Birth: _____ Referred By: _____

In case of emergency contact: _____ Phone#: _____

Insurance Information:

Name of Insured: _____ Policy#: _____

Insurance Carrier: _____ Phone# _____

Relationship to Insured: _____ Self _____ Spouse _____ Child/Financial Dependent

Employment Information:

Employer: _____

Address: _____

Card on File:

In order to expedite your billing, we prefer to have a card on file for payment of all fees, deductibles, co-payments & co-insurances. The card will be billed monthly & you will receive a paid statement with a receipt in the mail.

*Please be sure to indicate the card type, as a processing fee will be applied to payments made with a **credit card.***
Information regarding this fee can be found posted in our office.

Card Type: ☐ CREDIT ☐ DEBIT ☐ HSA/FSA ☐ Visa ☐ MasterCard ☐ American Express

Card#: _____ Exp: _____ **Security Code: _____

Patient Signature: _____ **Date:** _____