



120 East 56th Street
Suite 1010
New York, NY 10022
212-759-2211

36 West 44th Street
Suite 403
New York, NY 10036
212-759-2280

635 Madison Avenue
7th floor
New York, NY 10022
212-759-2282

PATIENT REGISTRATION

Should we thank any individual for referring you to S.P.E.A.R. Physical Therapy, PLLC?			Date
Full Name	DOB	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address			
City	State	Zip Code	
Home Telephone	Work Telephone	Mobile	
Social Security Number	Email Address		
Emergency Contact Name	Relationship	Emergency Contact Number	

INSURANCE INFORMATION

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name	Social Security Number
Address	
Telephone	Email Address

OPTIONAL CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize S.P.E.A.R. 44 th LLC and/or S.P.E.A.R. Physical Therapy, PLLC and/or the staff at 36 West 44 th Street, Suite 403, NYC, NY 10036 and/or 120 East 56 th Street, Suite 1010, New York, NY 10022 to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify S.P.E.A.R. Physical Therapy, PLLC any changes regarding this credit card authorization.		
Name on Card	Signature/Date	
Credit Card Type <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> Discover	Credit Card Number	
Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

Signature: _____ Date: _____