Nick Roselli Occupational Therapy
NR-OT The doctor's choice for personal care and results.

Appointment Date:_____ Time:_____

Last Name:_____ First:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone #: _____ Work:_____ Cell:_____

DOB: _____ Soc Sec #:_____ Email Address:_____

Relationship to guarantor: Self Spouse Child Other **Patient Status**: Single Married Student Other

REFERRING PHYSICIAN:_____ Phone #_____

Are you receiving Home Health assistance? Y N If Yes, please specify:_____

Are you currently attending any other Therapy? Y N If Yes, please specify:_____

Have you attended Therapy earlier this year? Y N If Yes, please specify:_____

NF: IS THIS THE RESULT OF AN AUTO ACCIDENT? Y N

Date of Accident_____ NF application filed with Ins.? Y N

Name of policy holder if not patient:_____

WC: IS THIS THE RESULT OF AN INJURY AT WORK? Y N

Date Of Injury_____

Injury reported to employer? Y N

Are you currently working? Y N

Patient Employer:_____

Employer Address:_____

Phone: _____

Patient Attorney:_____

Attorney Address:_____ Phone:_____

OFFICE USE ONLY

Body Part/ Diagnosis

1. _____
2. _____

Procedures

Splint:_____

1._____ 2._____

3._____ 4._____

Rx. Date: _____

PRIMARY INSURANCE INFORMATION

Subscriber's Name:_____ Employer:_____

D.O.B._____ Soc. Sec. #_____

Insurance Carrier:_____ Claims address_____

Adjuster Name:_____ Phone #_____ Fax #_____

Policy/Claim #_____ Group #_____

SECONDARY INSURANCE INFORMATION:

Subscriber's Name:_____ Employer:_____

D.O.B._____ Soc. Sec. #:_____

Insurance Carrier:_____ Claims address_____

Adjuster Name:_____ Phone #_____ Fax #_____

Policy/Claim #_____ Group #_____

SIGNATURE:_____ **DATE:**_____

931A Morris Park Ave.
Bronx, NY 10462
(718) 822- 4054

61-18 190th Street, Suite 201
Fresh Meadows, NY 11365
(718) 454-0842

2382 E13th Street
Brooklyn, NY 11229
(718) 891-9897

585 Plandome Rd., Suite 102
Manhasset, NY 11030
516-869-5576