

PATIENT INFORMATION

Name _____ Age _____ Marital Status _____ Sex _____
Address _____ City _____ Zip _____
Home Phone _____ Alternate Phone _____ Date of Birth _____
Diagnosis _____ Referring MD _____ Phone # _____
Employer _____ Social Security # (required for billing) _____

INSURANCE INFORMATION

Type of insurance (circle one) Blue Choice, Preferred Care, Medicare, Monroe Plan, BCBS, Other _____
COPAY amount \$ _____ Secondary Insurance Type _____ Subscriber # _____
Subscriber # _____ Referral # _____
Subscriber's Name _____ Home Phone # _____ Work Phone # _____
Subscriber's Address _____
Subscriber's Date of Birth _____ Relationship to patient _____

WORKERS COMPENSATION INFORMATION (INJURED AT WORK)

Employer(When Injured) _____ Date of Injury _____
Address _____ Zip _____ Phone # _____
Employer's Insurance Carrier _____ Claim # _____
Address _____ Zip _____ Phone # _____
Insurance Adjustor's Name _____ Phone # _____

NO FAULT INFORMATION (MOTOR VEHICLE ACCIDENT)

Policy Holder's Name _____ Relationship to patient _____
Address _____ Zip _____ Phone # _____
Insurance Carrier _____ Claim # _____
Insurance Carrier Address _____ Zip _____ Phone # _____
Insurance Adjustor Name _____ Phone # _____ Accident Date _____

OFFICE USE ONLY-----

Appointment Date: _____ Time: _____ Therapist: _____
Account # _____ Ret. _____ Chart Pulled _____

of visits approved _____
By Whom _____ Date _____
By Whom _____ Date _____
By Whom _____ Date _____
By Whom _____ Date _____

...IN THE PAST 2 YEARS?

Were you previously under the care of another physical therapist? **YES** **NO**

If yes please list dates and diagnosis

Circle if applicable: Hospital PT In-home PT Outpatient PT

Please list all medications that you presently take (or you may bring us a printout):

Do you have any of the following health conditions? (circle all that apply)

Diabetes *Cancer* *Seizures* *Stroke* *Epilepsy* *Heart Disease* *Allergies*
Disc Herniation *Bypass Surgery* *Osteoporosis* *Osteopenia* *High Blood Pressure*

Do you have a pacemaker? YES NO

If female, are you pregnant? YES NO

Please list all other diagnosis, conditions, and/or operations:

What is your current occupation? _____ Are you out of work due to injury? _____

Is this a work related injury? YES NO Is this a Motor Vehicle injury? YES NO

Describe your hobbies and activities: _____

Your goals for physical therapy are: (i.e. return to work, return to a sport or hobby, etc.)

Name and address of nearest relative not living with you: _____

In case of emergency contact: _____ Phone # _____

I hereby state the above answers are true. I consent willingly to physical therapy treatments. If patient is a minor, parent or guardian must sign.

Signature

Date