

Confidential Patient Information

Name _____ Date _____

Home # _____ Cell# _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital: **M S W D** How Many Children? _____

Height _____ Weight _____ Occupation _____ Employer _____

Address _____ Office Phone _____

Insured name if patient is a dependent _____

Name of Insurance Company _____ Address _____

Name of Husband/Wife _____

Patients nearest relative _____ Phone# _____

Is condition a work related accident? ___YES ___NO Date symptoms appeared or accident occurred _____

Patient ever had same or similar condition ___YES ___NO If Yes, when and

describe _____

Have you lost any days from work? _____

Date of last physical exam _____ Female: Are you pregnant? _____

What operations have you had? _____ Serious Illness _____

HAVE YOU EVER SUFFERED FROM: Check all that apply

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Ear Noises | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Slow Heart Beat |
| <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Kidney Infection or Stone | <input type="checkbox"/> Depression | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Prostate Trouble |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chest Pain | |

Tingling or numbness in: Check all that apply

Shoulders Hips Arms Legs Elbows Knees Hands

Additional

Information: _____

Please Print Clearly

Purpose of this appointment (Major Complaint)

What activities aggravate your condition?

Is this condition getting progressively worse? ___ Yes ___ No ___ Constant ___ Comes & Goes

Is this condition interfering with your work? ___ Work ___ Daily Routine ___ Sleep ___ Other

How long has it been since it really felt good? _____

What do you believe is wrong with you? _____

Have you seen other Doctors for this condition? _____

Have you been treated for any health conditions by a physician in the last year? ___ Yes ___ No Describe _____

Are you insured? Yes No

Insurance Company Name _____ POS PPO HMO EPO

Is there an FSA/HSA Account attached to this card? ___ Yes ___ No

Do you have a secondary insurance? Yes No

Insurance Company Name _____ POS PPO HMO EPO

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me making collections from the insurance company and then any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered are to be charged to directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

In accordance with Education Law section 6731(d), a physical therapist providing treatment in the practice of physical therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner, in accordance with Education Law section 6731(d) and the requirements of this section shall advise the patient in writing prior to beginning treatment of the possibility that treatment may not be covered by the patient's health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that treatment may be a covered expense if rendered pursuant to such referral. **For your convenience we have a medical doctor on staff that can evaluate you and prescribe physical therapy if necessary.**

Patient Signature _____

Date _____

Guardian or Spouse's Signature Authorizing Care _____

Date _____

Comments
