PhysicalTherapy

FOR OFFICE USE ONLY:
PIN: _____ THERAPIST: _____ Tx Diagnosis _____
RECORD #: _____ Blood Pressure : _____ MmHg Pulse : _____ bpm O2 : _____ %

PATIENT INFORMATION & MEDICAL HISTORY

NAME : _____ **TELEPHONE: (____)** _____ **E-Mail:** _____
SOCIAL SECURITY NUMBER: _____ **Date of Birth:** _____ **AGE:** _____ **GENDER:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
EMERGENCY CONTACT: _____ **TELEPHONE: (____)** _____
REFERRING PHYSICIAN: _____ **PRIMARY PHYSICIAN:** _____
REASON FOR THERAPY: _____ **DATE OF INJURY/ILLNESS:** _____

General Medical Information: Please fill out all the needed information and affix your signature on the spaces provided.

Do you now have or have you had any of the following?

❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Back problems	❑ Yes	❑ No	Poor eyesight/hearing
❑ Yes	❑ No	Heart attack / Heart By Pass	❑ Yes	❑ No	Metal Implants	❑ Yes	❑ No	History of Cancer
❑ Yes	❑ No	Pacemaker / Stent	❑ Yes	❑ No	Muscular Dystrophy	❑ Yes	❑ No	Seizure/Epilepsy
❑ Yes	❑ No	Surgery	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No	Polio
❑ Yes	❑ No	Hypertension	❑ Yes	❑ No	Osteoarthritis	❑ Yes	❑ No	Multiple sclerosis
❑ Yes	❑ No	Low blood pressure	❑ Yes	❑ No	Asthma	❑ Yes	❑ No	Gout
❑ Yes	❑ No	Fibromayalgia	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Diabetes
❑ Yes	❑ No	Carpal tunnel syndrome	❑ Yes	❑ No	Joint Replacement	❑ Yes	❑ No	Fainting spells
❑ Yes	❑ No	Shortness of breath	❑ Yes	❑ No	Joint Dislocation	❑ Yes	❑ No	Kidney problems
❑ Yes	❑ No	Nervous disorders	❑ Yes	❑ No	Circulatory disorders	❑ Yes	❑ No	Allergies
❑ Yes	❑ No	Sensitivity to Heat/Cold	❑ Yes	❑ No	COPD	❑ Yes	❑ No	Hepatitis /Infectious Dis.

❑ Yes ❑ No Are you presently taking medication? If yes, please specify: _____

❑ Yes ❑ No Have you had therapy for your present condition? If yes, please provide details: _____

❑ Yes ❑ No Is your injury job-related or a result of a vehicular accident? If yes, please answer the questions on the next page as well.

If you have answered YES to any of the questions above please explain and give approximate dates: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Policyholder: _____
Relationship to Patient: _____
Date of Birth: _____
SS#: _____
Insurance Co: _____
Policy #: _____

SECONDARY INSURANCE

Name of Policyholder: _____
Relationship to Patient: _____
Date of Birth: _____
SS#: _____
Insurance Co: _____
Policy #: _____

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Spine and Sports Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Spine and Sports Therapy for any services rendered to me by the Provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the HCFA 1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medical carrier.

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Spine and Sports Therapy updated as to any changes in my medical profile and understand that there shall be no liability on the Provider's part should I fail to do so. By my signature, I hereby certify that all the information provided is true and correct. Moreover, my signature signifies my agreement to the insurance and Medicare clauses stated above and give my consent for Spine and Sports Therapy to furnish medical care and treatment to which is considered necessary and proper in the diagnosing or treating of my physical condition.

PATIENT SIGNATURE: _____ **DATE:** _____