

CONFIDENTIAL PATIENT INFORMATION

Date _____

PLEASE ANSWER ALL QUESTIONS FRONT AND BACK. IF YOU NEED ASSISTANCE PLEASE ASK THE RECEPTIONIST. THANK YOU FOR THE OPPORTUNITY TO SERVE YOU.

NAME _____ BIRTHDATE _____ AGE ____ SS# _____

ADDRESS _____ MARITAL STATUS M S W D NUMBER OF CHILDREN _____

CITY, STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ E-Mail Address _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ OFFICE PHONE _____

NAME OF SPOUSE _____ SPOUSE OCCUPATION _____

SPOUSE EMPLOYER _____ OFFICE PHONE _____

PATIENT'S NEAREST RELATIVE _____ PHONE _____

Whom may we thank for referring us to you _____

If a phone book, which one: SBC (Ameritech) _____ or Yellow book (McLeod) _____

BRIEFLY EXPLAIN YOUR CONDITION _____

OTHER DOCTORS SEEN FOR THIS CONDITON _____

GENERAL HEALTH INFORMATION

DATE OF LAST PHYSICAL EXAM _____

WHAT OPERATIONS HAVE YOU HAD? WHEN? _____

SERIOUS ILLNESS? WHEN? _____

SERIOUS ACCIDENT? When? _____

KNOWN DRUG ALLERGIES: _____

HAVE YOU EVER SUFFERED FROM:

Dizziness	Y N	Sinus Trouble	Y N
Backaches	Y N	Heart Trouble	Y N
Headaches	Y N	Nervousness	Y N
Numbness	Y N	Anemia	Y N
Leg Pain	Y N	Cancer	Y N
Arm/Shoulder Pain	Y N	Diabetes	Y N
Burning/Ringing in Ears	Y N	Asthma	Y N
Arthritis	Y N	Allergies	Y N
Digestive Disorders	Y N	Fatigue	Y N

Have you been treated for any medical condition by a physician in the past year? Y N

Primary Insurance

Company Name _____ Name of Policyholder _____

Policy Number _____

Do you have any other medical insurance (are you covered on a spouses plan)? ___YES ___NO

If YES:

Company Name _____ Name of Policyholder _____

Policy Number _____

**ASSIGNMENT AND RESPONSIBILITY STATEMENTS
(Please read carefully)**

1. You may use your insurance coverage to pay a portion of your incurred medical expenses. However, you should be aware these insurance payments are not a substitute for your responsibility relative to incurred charges for service. It is your responsibility to pay for debts not covered by your insurance company, including deductibles and co-payments.
2. Our staff will file all of the necessary insurance claim forms and do everything in their power to insure smooth claim processing.
3. This form shall serve as an authorization for this office to:
 - A) Bill your insurance carrier for all services rendered,
 - B) Release any information necessary to process insurance claims,
 - C) Have any insurance benefits paid directly to this office.
 - D) Release any information necessary to other providers offices.
4. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE** until other financial arrangements are made. If care and treatment is suspended or terminated, any fees for professional services rendered will immediately due and payable in addition to any cost of collection, if applicable. Personal balances older than 30 days will have interest charges of 1.5% per month added.
5. **CONSENT FOR CARE** I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition (s). Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee our treatment will help the condition you are seeking treatment for. There is also a risk your treatment may cause pain or injury, or may aggravate previously existing conditions. Further, I authorize physical therapy treatments to be performed in an open bay area.

Patient Signature _____ **SS#** _____

Insured Signature _____ **SS#** _____

Guardian Signature authorizing care _____