

WAYNE PHYSICAL THERAPY & SPINE CENTER

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PATIENT INFORMATION

Date _____

Patient _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Sex M / F Birthdate _____ Age _____

Home Phone _____ Cell Phone (OK to call? Y / N) _____

E-mail address _____ Bus. Phone(OK to call? Y / N) _____

Occupation _____ Employer _____

Business Address _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Relationship _____ Phone _____

Have you retained an attorney because of your injury? Yes No If yes, attorney's name / address / phone

INSURANCE

Who is responsible for this account? _____ Relationship to patient _____

Birthdate _____ Soc. Sec. # _____

Insurance Company _____ ID # _____ Group _____

Is patient covered by additional insurance? Yes / No If yes, Insurance Co _____

Subscriber Name _____ Birthdate _____ Soc. Sec.# _____

ID # _____ Group _____ Relationship to patient _____

CONSENT FOR TREATMENT, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) consent to such evaluation & treatment procedures and patient care which, in the judgment of my therapist, may be considered necessary or advisable while a patient at Wayne Physical Therapy & Spine Center. I hereby authorize the release of any medical information to any agency handling my claims to secure processing and payment of benefits. I agree to have my medical records released to any of my medical doctors or medical facilities relating to my treatment. I authorize that payment of benefits be made directly to Wayne Physical Therapy & Spine Center for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize Wayne Physical Therapy & Spine Center to act on my behalf to report any suspected violation or improper claims practices by my insurance carrier to the proper regulatory agencies.

Responsible Party Signature (Parent/Guardian if minor) _____ Date _____

PATIENT NAME _____ DATE _____

To your best knowledge, do you have or have you had: (Please "X" the appropriate box)

- | | |
|---|--|
| Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/Tumor/Growths | <input type="checkbox"/> <input type="checkbox"/> Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> <input type="checkbox"/> CVA / TIA | <input type="checkbox"/> <input type="checkbox"/> Other arthritis (Please specify type) _____ |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Blood Disorders/Bleeding Tendencies |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pains/Angina | <input type="checkbox"/> <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Abdominal Pain/Blood in Stool/Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Fainting Episodes |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> <input type="checkbox"/> Dizziness/Lightheadedness |
| <input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Other Neurologic Disorder-please specify _____ |
| <input type="checkbox"/> <input type="checkbox"/> Polio | <input type="checkbox"/> <input type="checkbox"/> Psychological Disorder-please specify _____ |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> Other _____ |

Comments: _____

Medical Status/Tests

- Are you taking any prescription or over-the-counter medications? Yes No
If yes, please list: _____
- Are you allergic to any medications? Yes No
If yes, please list: _____
- Have you had any X-rays, sonograms, CT scans or MRI's done recently? Yes No
If yes, please list: _____
- Have you had any laboratory work done recently? (urine, blood tests, etc.) Yes No
If yes, please list: _____
- Please list any operation you have had within the last 2 years and the date(s) of surgery: _____
