Confidential Patient Information

Name____ Date_________________________

Home #_____________________Cell#____________________Email_________________________________

Address____ Apt#______________City_______________State___________Zip Code__________

Birth Date_______/_______/__________ Marital: **M S W D** How Many Children? _______

Height______ Weight_______ Occupation_____________________________

Employer_______________________________

Address______________________________ ______Work Phone____________________________

Name of Insurance Company_______________________________________

Insured name ______________________________ Insured DOB_______/_________/_________

Secondary Insurance ________________________ Insured Name___________________________

Relationship to Insured __________________________________

Emergency Contact________________________ ___Phone# ____________________________

Whom may we thank for referring you____

Is this a worker's compensation case or direct result of a no-fault accident? ____YES ____NO

Date symptoms appeared or accident occurred____________________

Primary Care Physician Name____ Physician Number________________________________

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

___Allergy ___Foot Trouble ___Sinus Infection ___Headache ___Dizziness

___Fatigue ___Low Back Pain ___High Blood Pressure ___Poor Posture ___Fatigue

___Neck Pain ___Low Blood Pressure ___Poor Circulation ___Loss of Sleep ___Sciatica

___Rapid Heart Beat ___Ulcers ___Arthritis ___Asthma ___Difficulty Breathing

___Spinal Curvature ___Bursitis ___Ear Noises ___Varicose Veins ___Slow Heart Beat

___Enlarged Thyroid ___Kidney Infection or Stone ___Depression ___Eye Pain ___Prostate Trouble

___Swollen Joints ___Failing Vision ___Irregular Cycle ___Stroke ___Venereal Disease

___Colon Trouble ___Tuberculosis ___Diabetes ___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 _________________

Please list all medications you are currently taking ____

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.**

I have been given the opportunity to review the HIPAA Patient Privacy Policy

Patient Signature _______________________________________ Date ___________________

Guardian or Spouse's Signature Authorizing Care _______________________ Date ___________________