"Setting the standards for personal care"

PHYSICAL THERAPY ASSOCIATES

Patient Information:

Name:____ Date of Birth: ___/___/_____ Sex: M / F
First Middle Last MM DD YYYY (circle one)
Social Security Number: __ __ __-__ __-__ __ __ __ Drivers License #____________________(for identification purposes only)
Address:____
Street P.O. Box City State Zip Code
Phone: Home: (_____)__ __ __-__ __ __ __ Emergency Contact:___________________________
Work: (_____)__ __ __-__ __ __ __ Emergency Phone: (____)__ __ __-__ __ __ __
Cell: (_____)__ __ __-__ __ __ __
Email: _______________________

Employment Status: (circle) Full time Part time Retired Unemployed Employer Name:___________________________________

Occupation: __________________________________ Is this a work related injury? Y / N
If So, please provide Workmen's Comp Carrier:____________________________ Phone: (____)__ __ __ - __ __ __ __
Do you have an attorney representing you in this matter? Y / N
If so, please provide: Attorney Name:___________________________________ Attorney Phone: (____) __ __ __ - __ __ __ __

*Insurance benefits quoted by staff are not a guarantee of coverage. Questions about your benefits should be directed to your insurance company. You must provide your insurance card to ensure accurate filing.

Primary Insurance Name:________________________________ Relationship to insured: (circle) Self Spouse Parent

Secondary Insurance Name:______________________________

What are we treating you for today?______________________________ Date of onset or injury :___/_____/______

How did this occur? ____ Referring Physician:________________________

What medications do you take & how often?____

Do you have metal implants ? Y / N Do you have other health problems? Y / N _________________________________
(I.U.D., wires, pins, screws, or artificial joints) (heart problem, high blood pressure, etc)

Privacy Authorization:
I have received a Notice of Privacy Policies and know that I may review or obtain a copy at any time at the offices of Ellis Physical Therapy Associates, Inc.
Please Sign X:__________________________________Date:______________

Release of information:
Medical records are confidential and will only be used and disclosed as described in the Notice of Privacy Practices. Please list the individuals authorized to obtain information about you and circle what information they may obtain.
Name of individual:____________________________Type of info: Medical Y / N Billing Y / N Insurance Y / N
Name of individual:____________________________Type of info: Medical Y / N Billing Y / N Insurance Y / N
Please Sign X:___________________________________Date:________________

Informed Consent:
I hereby consent to and authorize Ellis Physical Therapy Associates, Inc. and the therapist in charge of my treatment to perform examinations and treatments which may in his/her opinion be necessary.
Please Sign X:__________________________________Date:________________

Internal Use Only:
Chart #__________________________________Diagnosis:____