Wayne Physical Therapy & Spine Center

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PATIENT INFORMATION

Date _____

Patient _____ SS# (parent's if minor) _____

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? _____ (patient unless minor or WC)

Who is the insured? _____ 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 _____

Wayne Physical Therapy & Spine Center **PAST MEDICAL HISTORY**

PATIENT NAME _____ DATE _____

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

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

Comments: _____

Medical Status/Tests

1. Are you taking any prescription or over-the-counter medications? ☐ Yes ☐ No

   If yes, please list: _____

2. Are you allergic to any medications? ☐ Yes ☐ No

   If yes, please list: _____

3. Have you had any X-rays, sonograms, CT scans or MRI's done recently? ☐ Yes ☐ No

   If yes, please list:_____

4. Have you had any laboratory work done recently? (urine, blood tests, etc.) ☐ Yes ☐ No

   If yes, please list: _____

5. Please list any operation you have had within the last 2 years and the date(s) of surgery: _____

   _____