

SWANNER PHYSICAL THERAPY



NEW PATIENT INFORMATION

Patient Name _____	Date of Birth _____	Age _____
Address _____	Social Security No. _____	
City, State, Zip _____	Home Phone _____	
Driver's License # _____	Name of Spouse _____	
Marital Status (circle one): Single Married Divorced Widowed		Sex (circle one): M F
Referring Physician _____	Phone _____	

Employer _____	Work Phone _____
Address _____	Occupation _____
City, State, Zip _____	Full time _____ Part time _____
Student? Yes _____ No _____ If yes, please check one:	Full time _____ Part time _____
If student, name of responsible party/parent _____	

Is this a personal injury or motor vehicle accident? Yes _____ No _____ If yes, date of injury _____
Is your injury work-related? Yes _____ No _____ If yes, date of injury _____
Do you have an attorney involved in this case? Yes _____ No _____
If yes, please provide: Name _____ Phone _____
Street Address _____ City, State, Zip _____

Insurance Information: (Circle One) Worker's Comp. Medicare Pvt. Insurance Cash Lien
Insurance Carrier _____ Policy No. _____
Street Address _____ Group No. _____
City, State, Zip _____ Claim No. _____
Contact Person/Adjuster _____ Phone _____

I authorize payment of medical benefits to "Swanner Physical therapy" as indicated on the itemized bill. I authorize Swanner Physical Therapy to release medical and billing information required to process claims for payment or as necessary for care in the course of my therapy. I understand that Swanner Physical Therapy is billing my insurance as a courtesy, and that I am ultimately responsible for the charges.

Signed _____ Date _____

SWANNER PHYSICAL THERAPY



CURRENT AND PAST MEDICAL HISTORY

AS FAR AS YOU ARE CONCERNED, WHAT IS YOUR MAIN PROBLEM?

WHEN DID IT START?

DID YOU HAVE SURGERY FOR THIS PROBLEM _____ WHEN? _____

HAVE YOU EVER HAD X-RAYS, MRI OR SPECIAL TESTING? _____

IF SO, WHAT WERE THE RESULTS OF THIS TESTING? _____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

DIABETES?	YES _____	NO _____
HIGH BLOOD PRESSURE?	YES _____	NO _____
HEART PROBLEMS OR HEART DISEASE?	YES _____	NO _____
PACEMAKER?	YES _____	NO _____
PRIOR SURGERIES?	YES _____	NO _____
SEIZURES?	YES _____	NO _____
METAL IMPLANTS?	YES _____	NO _____
ALLERGIES?	YES _____	NO _____
A STROKE?	YES _____	NO _____
CANCER?	YES _____	NO _____

PLEASE EXPLAIN ANY "YES" ANSWERS _____

ARE YOU PREGNANT? YES _____ NO _____

ARE YOU CURRENTLY WORKING? YES _____ NO _____

IF NOT, IS IT BECAUSE OF YOUR INJURY? _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO "SWANNER PHYSICAL THERAPY" AS INDICATED ON THE ITEMIZED BILL. I AUTHORIZE SWANNER PHYSICAL THERAPY TO RELEASE MEDICAL AND BILLING INFORMATION REQUIRED TO PROCESS CLAIMS FOR PAYMENT OR AS NECESSARY FOR CARE, IN THE COURSE OF MY TREATMENT.

SIGNED _____

DATE _____

SWANNER PHYSICAL THERAPY



ASSIGNMENT OF BENEFITS / CONSENT TO TREATMENT

PATIENT RESPONSIBILITY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, hereby assign all medical benefits to which I am entitled to Swanner Physical Therapy in the event they file insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize Swanner Physical Therapy to release all information necessary to secure the payment of said benefits. A copy of this agreement shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Swanner Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Patient's Signature

Date

NOTICE OF NONDISCRIMINATION

Pursuant to TITLE IV of the Civil Right Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, Swanner Physical Therapy does not discriminate in the provision of services on the basis of race, color, national origin, disability or age.

Patient's Initial