

# 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 \_\_\_\_\_