

Section I: Personal

Date: _____
Name: _____ **Social Security #:** _____
Address (No P.O. Box): _____ **Apt/Unit/FL:** _____ **City** _____ **State** _____
Zip Code _____ - _____ **Home Phone:** (____) _____ **Cell:** (____) _____
Email: _____ **Date of Birth** ____/____/____ **Age** _____ **Gender:** Female Male
Marital Status: _____ Single Married Divorced Widow **Are you a minor?** Yes No

Guarantor Information:
 Mother Father Spouse Partner
Name _____
Address _____
City/State/Zip Code _____
Date of Birth ____/____/____

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 Mother Father Spouse Partner
Name _____
Address _____
City/State/Zip Code _____
Date of Birth ____/____/____

Emergency Contact: Name _____
Telephone (____) _____ **Relationship** _____
Is this a Work Related Injury? Yes No **Date of Injury:** ____/____/____ **Note:** Assure you complete Section II.
Is this a Motor Vehicle Collision? Yes No **Date of Injury:** ____/____/____ **Note:** Assure you complete Section II.
Referred By: Doctor (Specify): _____ Friend Website Advertisement (Specify): _____

Section II: Accident Information

Type of Accident: Work Auto Home Other (Specify): _____
To whom have you made a report of your accident? Workers' Compensation Auto Insurance Other
Insurance Carrier: _____
Billing Address: _____ **City:** _____ **ST** _____ **Zip Code:** _____
Claim#: _____ **Contact Person:** _____ **Telephone:** (____) _____
Attorney Information (if applicable): _____ **Telephone:** (____) _____
Address: _____ **City:** _____ **ST** _____ **Zip Code:** _____

Section III: Insurance Information

Primary Insurance:
 Self Spouse Father Mother
Insurance Name _____
Name of Policy Holder _____
ID # _____
Group # _____

Primary Insurance:
 Self Spouse Father Mother
Insurance Name _____
Name of Policy Holder _____
ID # _____
Group # _____

Section IV: Employment

Employment Information:
 Self Spouse Father Mother
Employer _____
Address _____
City/State/Zip Code _____
Work Phone# (____) _____
Occupation _____

Employment Information:
 Self Spouse Father Mother
Employer _____
Address _____
City/State/Zip Code _____
Work Phone# (____) _____
Occupation _____

Section V: Medical History

Weight _____

Do you smoke? Yes No If yes, how much/often? _____

Do you drink alcohol? Yes No If yes, how much/often? _____

Do you use any illegal drugs? Yes No If yes, please describe: _____

Do you have any allergies? Yes No If yes, please describe: _____

Please CHECK any of the following conditions that you have had or currently have:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Paralysis, muscle weakness
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Cancer	<input type="checkbox"/> Foot Trouble
<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Disc Trouble	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Coughing Up Blood	<input type="checkbox"/> Albumin/Sugar in Urine
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Goiter/Thyroid Trouble
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Disabling Headaches	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Blood Disease/Anemia
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Gallbladder Trouble	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach Trouble/Ulcer
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Trick/Locked Joint

List of recent/current medications:

NAME

List any surgeries you have had:

PROCEDURE	YEAR	SURGEON

Section VI: Assignment and Release

AUTHORIZATION TO LEAVE A MESSAGE ON VOICEMAIL/ANSWERING MACHINE:

I hereby authorize Function^{1st} Physical Therapy, LLC to leave a message on my voicemail /answering machine to confirm appointments, leave insurance and/or medical information. _____ (INITIALS)

CANCELLATION / NO SHOW POLICY:

I hereby understand that I am to cancel / reschedule an appointment at least 24 hours prior to scheduled appointment. Otherwise, I will be assessed a cancellation fee based on type of treatment. _____ (INITIALS)

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES:

I hereby authorize Function^{1st} Physical Therapy, LLC Centers to release any information acquired in the course of my therapy treatment. _____ (INITIALS)

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: (Go to *Workmans' Comp Section* if Work Related Injury)

I hereby authorize my insurance company to forward payment directly to Function^{1st} Physical Therapy, LLC for services rendered. I acknowledge and understand that I am responsible for all of the charges of the services rendered to myself or family member listed within my insurance carrier. I, as insured, remain responsible for prompt payment of all services regardless of insurance coverage.

_____ (INITIALS)

I also understand that I will be charged for all collections costs and reasonable attorney fees. (Note: 25% collection fee added to account balance) _____ (INITIALS)

***WORKMANS' COMPENSATION SECTION* AUTHORIZATION TO RELEASE INFORMATION TO EMPLOYER & INSURANCE CARRIER**

I hereby authorize Function^{1st} Physical Therapy, LLC to release any information acquired in the course of my evaluation and/or treatment. _____ (INITIALS)

I hereby agree to personally accept responsibility for the payment of any fees that are incurred as a result of treatment if this injury is disputed as not being a work injury claim for any reason. (Note: Payment is considered past due 60 days of treatment date and is subject to a 12% annual interest charge. _____ (INITIALS)

I hereby acknowledge that I've read, understood and completed the above information to the best of my knowledge.

Signature _____

Date _____