SUMMIT
PHYSICAL THERAPY

Patient Information

Today's Date:_____

Patient Name:_____
Last First Initial

Street Address:_____

City:_____ State:_____ Zip:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ **Cell phone**:_____

Call reminder: ☐ **Text* reminder**: ☐
*Note by choosing text reminders you authorize certain PHI to be disclosed (ie: name, appointment information)

Email address:_____

Birthdate:_____ **Sex**: M F

Soc. Sec. #:_____-_____-_____ (optional)

Please complete the following as applicable:

Employer:_____ **Phone**:_____

Business Address:_____

City:_____ State:_____ Zip:_____

Occupation:_____

Marital Status (circle one): S M W D

Spouse Name:_____

Employer:_____ Phone:_____

Birthdate:_____

Please complete if patient is a minor or dependent:

Mother's Name: _____

Employer:_____ Phone:_____

Birthdate:_____ Soc. Sec. #:_____-_____-_____

Father's Name: _____

Employer:_____ Phone:_____

Birthdate:_____ Soc. Sec. #:_____-_____-_____

Closest Relative or Friend (not living with you):

Name:_____ Phone:_____

Address:_____ City/ST:_____

Do you have a follow-up appointment with the doctor who referred you to physical therapy?

☐ YES Date of appointment:_____

Referring Dr. _____

☐ NO, I am to call the doctor to schedule a follow up

☐ NO, doctor did not request to see me again

Insurance Information:

Is this a Motor Vehicle Accident claim? ☐ YES ☐ NO

If yes, Date of injury:_____ State: _____

Is this a Workman's Comp. claim? ☐ YES ☐ NO

If yes: Date of injury_____

Claim # (if work. comp. or MVA):_____

Primary Ins:_____

ID#:_____ Group #:_____

Address:_____

_____Phone:_____

Secondary Ins:_____ ID#:_____

Address:_____

_____ Phone:_____

How did you hear about Summit Physical Therapy?

____ Physician

____Advertising

____Friend/Family Whom?_____

Summit Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered individual and the insurance company***. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

☐ I hereby consent to such physical therapy procedures as may be rendered by Summit Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Summit Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $25.00 fee will be charged for returned checks. Summit Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Summit Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

☐ I acknowledge that I have been informed and notified of the whereabouts of Summit Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

_____

Patient/Guardian's Signature **Date**

SUMMIT PHYSICAL THERAPY

NAME_____DATE_____

Why did you come to Eagle Physical Therapy (what are your symptoms?) _____
_____

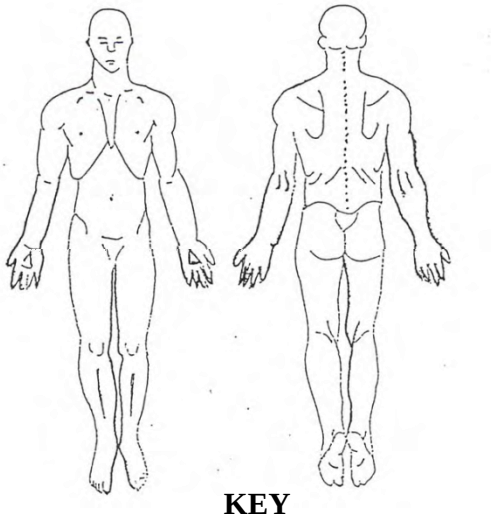
Date of Onset: _____ Date of Surgery (if applicable): _____

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible _____

Do you have or have you had any of the following:

	Yes	No
Diabetes	❒	❒
Osteoarthritis	❒	❒
Osteoporosis	❒	❒
Pacemaker	❒	❒
Headaches	❒	❒
Cancer	❒	❒
Ringing in your ears	❒	❒
Rheumatic Arthritis	❒	❒
Hypoglycemia	❒	❒
High Blood Pressure	❒	❒
Heart Disease	❒	❒
Dizziness/Fainting	❒	❒
Surgeries	❒	❒
Bowel/Bladder Abnormality	❒	❒
Urine Leakage	❒	❒

Please indicate below where your symptoms are located:



KEY
Numbness =======
Pins and Needles 00000000
Burning Pain XXXXX
Stabbing Pain / / / / / / / / /

If you answered YES to any of the items above, please briefly explain and give the date.

_____
_____

Do you have any allergies? Y N If yes, please list_____

Have you had 2 or more falls or a fall resulting in injury in the past 12 months? Y N

Are you presently taking any medication/supplements (prescription or over the counter)? Y N
If yes, please list medications:

Medication Name: **Dosage/Frequency** **Route (ie: oral, cream)**

_____
_____
_____
_____

What activities do you participate in and would like to return to/continue after therapy?

❒ Aerobics/Yoga ❒ Bicycling ❒ Cardio Machines ❒ Cross Country Skiing ❒ Dancing
❒ Downhill Skiing ❒ Gardening ❒ Golf ❒ Hiking ❒ Running ❒ Swimming ❒ Tennis
❒ Walking ❒ Weight Training ❒ Youth/HS sports ❒ Other_____

What would you like to accomplish with therapy (what are your goals)?_____