

# PATIENT INFORMATION

Please Print and Complete ALL Entries

Today's Date: / /	Referring Physician:	Primary Care Physician:	Date of MD follow up: / /
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## PATIENT INFORMATION

Patient's last name:		First:	MI:	Date of Birth: / /	Age:
Street address:			City:	Zip:	
E-mail:		Social Security Number: - - - - -	Main phone #: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work ( )		
Marital Status:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employer: (or Subscriber Employer)	Alt phone #: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work ( )		
Emergency contact last name:		First Name: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Friend	Emerg Contact Phone number: ( )		
How did you hear about us? <input type="checkbox"/> Medical provider <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Outside Sign <input type="checkbox"/> Friend _____ <input type="checkbox"/> Other _____					

## INSURANCE INFORMATION

<b>Would you like your insurance benefit amounts for physical therapy reviewed with you? <input type="checkbox"/> YES <input type="checkbox"/> NO</b>			
Insurance Company(ies) to be billed:		Policy / Claim ID Number:	
Is the Insurance Primary Subscriber also the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, disregard next line			
Insurance Subscriber's last name:	First:	Subscriber Date of Birth: / /	Relation to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD (if applicable)

## MEDICAL HISTORY

Injured Body Part(s):	<input type="checkbox"/> Right	Date of Injury: ____ / ____ / ____	How Injury Happened: (if applicable)
	<input type="checkbox"/> Left	Date of Surgery: ____ / ____ / ____	
Accident related? <input type="checkbox"/> Not an accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Other			

List Medications:

Related Past Injuries/Illnesses/Surgeries:

Do you have any of the following?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Are you Pregnant?
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Bloodborne Infectious Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Polio	<input type="checkbox"/> Pins or Metal Implants
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Numbness or Tingling

## INSURANCE REIMBURSEMENT POLICY

Regardless of your insurance benefits, you are responsible for your bill. Benefits quoted are not a guarantee of payment. By signing this form, you agree to assign benefits to be paid directly to 3Dimensional PT, Inc for the amount of the account.

## TREATMENT AND BILLING AUTHORIZATIONS

The information provided by me is true to the best of my knowledge. I authorize 3Dimensional PT, Inc to treat myself or my dependent. Release of my my medical information regarding physical therapy treatment may be provided to my insurance company for the purpose of processing my medical, and also to appropriate medical provider(s) of care for coordination of care.

## PRIVACY PRACTICES SUMMARY

By signing this form, I am acknowledging that I have the option to receive a copy of 3Dimensional Physical Therapy's Statement of Privacy Practices, or have declined to receive a copy. I understand that I can get a copy of the aforementioned Statement of Privacy Practices at any time upon request. The statement explains how we use and disclose your health information. If for payment purposes your insurance company requests a copy of your medical records, we will release the requested records to your insurance company. For optimal treatment, we also share information regarding your injury/illness with your doctor. If for any reason you do not wish for either your doctor or insurance company to have copies of your records, or any party described in our Privacy Practices, you must inform 3DPT in writing. 3Dimensional Physical Therapy may also release medical information about you to a family member or a friend involved in your medical treatment or payment of your medical bills. Unless specified, 3DPT may also leave messages at your home/work regarding appointments or if we need you to contact us. By signing below, you are agreeing to the terms described above.

Patient/Guardian Signature:	Date:
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