

MCLAUGHLIN PHYSICAL THERAPY & SPORTS MEDICINE

Patient Name _____ Today's Date _____

Address _____ City/Town _____ Zip Code _____

Telephone# (Home) _____ (Work) _____

Social Security# _____ Date of Birth _____

Employer: _____ Address _____

Occupation: _____

PRIMARY INS. CO. NAME: _____

Subscriber's Name: _____ Employer: _____

ID# _____ Date of Birth: _____ Relationship to Patient _____

Group# _____ Social Security # of Card Holder _____

SECONDARY INS. CO. NAME: _____

Subscriber's Name: _____ Employer: _____

ID# _____ Date of Birth: _____ Relationship to Patient _____

Group# _____ Social Security # of Card Holder _____

WORKER'S COMP./LIABILITY Please provide the following information:

Insurance Company: _____ Date of Injury: _____

Address: _____ Claim #: _____

Claim Representative: _____ Telephone: _____

I hereby acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, unless other arrangements are made in advance with the office. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself; any co-pays, deductibles or co-insurances not covered by insurance are my RESPONSIBILITY. I will take the responsibility for any and all costs incurred by my failure to remit claims for services rendered. I authorize payment of medical benefits to McLaughlin Physical Therapy & Sports Medicine Clinic for services rendered. I also authorize the release of any information required to insurances, adjusters, or attorneys for the purpose of processing my claims.

Please list names of persons with whom you authorize our discussing your personal information:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

I HAVE READ THE ABOVE STATEMENT AND ACKNOWLEDGE THAT ALL INFORMATION PROVIDED IS CORRECT. PLEASE SIGN BELOW TO AUTHORIZE TREATMENT.

Patient or Parent/Guardian Signature: _____ Date Signed _____

NO SHOW POLICY: All patients will be responsible for a \$50.00 No Show Fee if that patient fails to notify this office within 24 hours of their designated appointment.

PLEASE FILL OUT THE INFORMATION ON THE BACK OF THIS SHEET ALSO. THANK YOU.

Name of doctor referring you to McLaughlin P.T. _____

Date of next doctor's visit: _____

I was referred to your facility by: (check one) doctor ___ friend/relative ___ ins.co. ___ phone book ___

Have you been here before? No ___ Yes ___ If yes, when? _____

Medical History:

Height _____ Weight _____ Age _____

Are you disabled? Yes ___ No ___ If yes, how long? _____

How did problem occur? _____

Please indicate the area of body affected: neck-back-arm-leg-knee or other area

(indicate here) _____

Is the pain continuous? Yes ___ No ___ Does it wake you up? Yes ___ No ___

Please circle activities that make the pain worse:

walking---sitting---standing---driving---bending---lifting---coughing---sneezing---lying down

What position or activity improves your symptoms? _____

Circle symptoms you have: numbness--bowel or bladder problems—weakness—cramps

--other (explain) _____

Circle treatment(s) that you have previously had: none--physical therapy--chiropractic—bracing—other.

Where were you treated? _____ Apprx. # visits _____

Was it for the same problem? Yes ___ No ___

What medications are you currently taking? _____

Have you had any surgeries? Yes ___ No ___ Type _____ When _____

Have you had any recent x-rays, MRI, CT scans? yes ___ No ___ Type _____ When _____

Please circle if any of the following apply to you: High blood pressure--Stroke--Aids--Diabetes--Rheumatic Fever--Hepatitis--Ulcers--Arthritis--Bleeding problems--Heart problems--Kidney stones--Immune problems--Fainting spells--Hearing Impaired--Implants--Bone Disorders

Cancer: Type _____ Where _____

Neurological diseases (explain): _____

Do you smoke? Yes ___ No ___ Packs per day? _____ For how long? _____

In case of emergency, whom should we notify?

Name _____ Phone#: _____

Relationship: _____