



Patient Name First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Preferred Name \_\_\_\_\_ Address Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SSN \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Health Insurance Company \_\_\_\_\_

Insurance ID card copied for chart \_\_\_\_\_

You must complete if you are not the insured: First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to insured \_\_\_\_\_

Secondary Health Insurance Company \_\_\_\_\_

Insurance ID card copied for chart \_\_\_\_\_

You must complete if you are not the insured: First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to insured \_\_\_\_\_

Is there someone with whom you would like us to be able to discuss your on going care? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Were you involved in an accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give details \_\_\_\_\_

Name of attorney \_\_\_\_\_

PPT's policy is to file your insurance at the time of service as a courtesy to patients; however, if you have commercial insurance, are self-pay, or are out of network, you will be asked to pay at time of service. If your insurance has not paid within 60 days, you will be responsible for all charges incurred. We will accept cash, personal checks, or credit cards (Visa, MC, and Discover). I understand that I am ultimately responsible for charges incurred at PPT regardless of third party liability. Initial \_\_\_\_\_

It is important to recognize that the appointment time given to you is reserved for you alone, as we do not double book our schedule. We schedule appointments in this fashion to minimize any waiting on your part. We require at least 24 hours notice if you need to reschedule. Should an emergency arise which causes you to miss or be late for an appointment, we ask that you call as soon as possible. Initial \_\_\_\_\_

There is a \$25 charge for cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally. Initial \_\_\_\_\_

Consent to Treat and Authorization to Release Information

I consent to evaluation and treatment by PPT and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize the release of information acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

I authorize phone messages regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

A copy of this facility's Statement of Privacy Notice has been provided to me. Initial \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_  
(if different than patient)



Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

The following confidential information will assist us in treating you more effectively. Discuss questions with your therapist.

1. Have you ever been diagnosed or treated for any of the following? (please check)

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Emphysema                 |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Migraine Headaches        |
| <input type="checkbox"/> Hypertension / High Blood Pressure | <input type="checkbox"/> Ulcers / Stomach Problems |
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Allergies                 |
| <input type="checkbox"/> Angina/Chest Pain                  | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Shortness of Breath / Asthma       | <input type="checkbox"/> Recent Weight Loss / Gain |
| <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Epilepsy / Convulsions    |
| <input type="checkbox"/> Kidney Disease / Infection         | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Insomnia                           | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Osteoporosis                       | <input type="checkbox"/> Rheumatoid Arthritis      |
| <input type="checkbox"/> Hepatitis / Liver Disease          | <input type="checkbox"/> Chills / Night Sweats     |

2. List any past surgeries, hospitalizations and dates \_\_\_\_\_

\_\_\_\_\_

Do you have any implants? (plates, screws, staples) Yes \_\_\_\_\_ No \_\_\_\_\_

3. Have you had any x-rays, sonograms, computed tomography (CT), or magnetic resonance (MRI) done lately? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain when, where and the results \_\_\_\_\_

\_\_\_\_\_

4. Have you had any lab work recently? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain when, where and the results \_\_\_\_\_

\_\_\_\_\_

5. List types of prescriptions and over-the-counter medications you are taking \_\_\_\_\_

\_\_\_\_\_

6. Do you smoke cigarettes, a pipe, or chew tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_

7. FOR WOMEN ONLY:

a. Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

b. Are you menopausal? Yes \_\_\_\_\_ No \_\_\_\_\_

c. Are you taking estrogen / hormonal replacement therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

8. Have you had physical therapy before? Yes \_\_\_\_\_ No \_\_\_\_\_

9. When do you return to see your physician? \_\_\_\_\_

Signature of person completing form \_\_\_\_\_ Date \_\_\_\_\_

Referred by \_\_\_\_\_ Date \_\_\_\_\_