Date: ____________________

Referring Doctor: _____________________

PATIENT INFORMATION

Last Name: ____________________________First: ____________________M.I.: ____

Address: ____Apt: _____

City: ____State: _____Zip: _________

Phone Numbers: Home: ____________________Cell: ___________________________

Email address:____
Would you like to receive our free monthly e-mail newsletter? Yes ______ No ______

Date of Birth: ______________________SS#: __________________Sex: ____M____F

Marital Status: M ____S _____D _____W ____Spouse's Name: ___________________

Is this injury related to:

Work? Yes ____No ____ Auto Accident? Yes ____No ____ Other? Yes ____No ___

Date of Injury: _____________________Is there an attorney involved? Yes____ No____

PATIENT WORK INFORMATION

Employer's Name: ____

Employer's Address: ____

City: ____State: ________Zip: _________

Work Phone Number: _______________________________Ext: __________________

WORKERS COMP INSURANCE

Workers Comp Carrier: ____

Address: _____________________________________State: _______Zip: __________

Insurance Adjustor: __________________Claim #: _____________________________

PLAYA
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Name: ___________________________ Age:__________ Referring Physician:_____________________________

Family Physician: ______________________ Date of First Doctor Visit for This Injury/Condition: _______________

Date of onset of Symptoms/Injury: __________ Injury Type: Auto ___ Work Related ___ Other: _____________

Have you had surgery for this Injury/Condition: YES NO
Type of Surgery: ____ Date(s) of Surgery: ______________________

Are you currently taking any Prescription or Non-Prescription Medications: YES NO
Please list:____

Are you Allergic to any medications: YES NO List Medications: ________________________________

Last Date Worked Due to this Injury/Condition: __________ Date Returned to Work after this Injury/Condition: _______
Is an Attorney Involved in this Case: YES NO

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	____	____	CT Scan	____	____
EMG/NCV	____	____	General Practitioner	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room Care	____	____	X-Rays	____	____
Other:					

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of Breath/Chest Pain	____	____	Vision or Hearing Difficulties	____	____
Coronary Heart Disease or Angina	____	____	Numbness or Tingling	____	____
Do you have a Pacemaker?	____	____	Dizziness of Fainting	____	____
High Blood Pressure	____	____	Bowel or Bladder Problems	____	____
Heart Attack or Surgery	____	____	Weakness	____	____
Stroke/TIA	____	____	Weight Loss/Energy Problems	____	____
Congestive Heart Disease	____	____	Hernia	____	____
Blood Clot/Emboli	____	____	Varicose Veins	____	____
Epilepsy/Seizures	____	____	Allergies	____	____
Thyroid Disease or Goiter	____	____	Any Pins or Metal Implants	____	____
Anemia	____	____	Joint Replacement Surgery	____	____
Infectious Diseases	____	____	Neck Injury/Surgery	____	____
Diabetes	____	____	Shoulder Injury/Surgery	____	____
Cancer or Chemotherapy/Radiation	____	____	Elbow/Hand Injury/Surgery	____	____
Arthritis	____	____	Back Injury/Surgery	____	____
Osteoporosis	____	____	Knee Injury/Surgery	____	____
Gout	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Sleeping Problems/Difficulties	____	____	Are You Pregnant?	____	____
Emotional/Psychological Problems	____	____	Do You Use Tobacco?	____	____

List any other information that would assist us in your care: ____

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO What are your rehabilitation expectations/goals while in this physical therapy program? ____

Patient/Responsible Party Signature: ____ Date: ____________

MEDICARE INFORMATION

Medicare Number: ____

PRIVATE INSURANCE INFORMATION

Insured Person Name: ___________________________Is this your coverage? Y N

Insured Date of Birth: ______________________Relationship to Patient: __________

Policy Number: ___________________________Group Number: ________________

Insurance Company Name: ____

Address: ___________________________________State: ______Zip: ___________

Phone Number: _____________________________Contact: ____________________

SECONDARY INSURANCE

Insured Person Name: ____

Insured Date of Birth: _____________________Relationship to Patient: ___________

Policy Number: ___________________________Group Number: ________________

Insurance Company Name: ____

Address: ___________________________________State: ______Zip: ___________

Phone Number: _____________________________Contact: ____________________

Authorization to Release Information and Assignment of Benefits:
I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plan to Playa Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Signature: ____________________________________ Date: ___________