



ADVANTAGE PHYSICAL THERAPY

PERSONAL INFORMATION

PLEASE COMPLETE ALL SECTIONS		
NAME	HOME PHONE	CELL PHONE / CARRIER
ADDRESS	CITY	ZIP CODE
EMPLOYER	WORK PHONE	
BIRTHDATE	EMAIL ADDRESS	SEX
MARITAL STATUS	REFERRING PHYSICIAN:	
SOCIAL SECURITY NUMBER	PREFERRED METHOD FOR NOTIFICATION OF APPOINTMENTS: ____EMAIL ____TEXT MESSAGE	
EMERGENCY CONTACT NAME	PHONE	RELATIONSHIP

INSURANCE INFORMATION

If we are filing with your general health insurance, and you have provided a copy of your insurance card, you do not need to fill out the following section. However, if your injury was due to a motor vehicle accident or a worker's comp injury, the following section is required.		
INSURANCE COMPANY	PHONE NUMBER	
ADJUSTOR'S NAME	EXTENSION NUMBER	
BILLING ADDRESS	CITY	ZIP
CLAIM NUMBER	DATE OF INJURY	
PLACE OF ACCIDENT	IS THIS WORK RELATED	

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Advantage Physical Therapy of any changes in the above information.

SIGNATURE

DATE

PARENT OR GAURDIAN (IF MINOR)

DATE



ADVANTAGE PHYSICAL THERAPY

MEDICAL HISTORY

1. What are you being seen for today? _____
2. Who is your referring physician? _____
3. When was the onset of your symptoms and/or injury: ____/____/____
3. Has a physician ever warned you against exercise: ☐ yes ☐ no
If yes, please explain: _____
4. Are you currently engaged in any form of exercise: ☐ yes ☐ no
If yes, please explain: _____
5. Are you currently working full duty: ☐ yes ☐ no
If no, please list any limitations: _____

If you are not working due to your injury, when do you anticipate returning to work: ____/____/____
6. Have you ever been diagnosed by a physician with any of the following:

<input type="checkbox"/> History of cancer	<input type="checkbox"/> Cardiac Disease	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Myofascial pain
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis	
7. Have you experienced any of the following symptoms in the past two weeks:

<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> Illness or fever	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Abdominal or chest pain	<input type="checkbox"/> Severe fatigue
8. Are you pregnant: ☐ yes ☐ no
9. Please list any medical conditions not mentioned above:

10. Please list all current medications:

11. Have you ever been treated by a Physical Therapist for this injury: ☐ yes ☐ no
If yes, please explain: _____
12. Are you undergoing, or have you undergone any other treatment for this injury: ☐ yes ☐ no
If yes, please explain: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE

PLEASE PRINT NAME



CONSENT FOR TREATMENT:

I hereby give my permission for Advantage Physical Therapy to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time

SIGNATURE

DATE

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to Advantage Physical Therapy to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Advantage Physical Therapy.

SIGNATURE

DATE

AUTHORIZATION FOR PAYMENT OF BENEFITS:

I authorize Advantage Physical Therapy to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although Advantage Physical Therapy will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold Advantage Physical Therapy, responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

SIGNATURE

DATE

MEDICARE PATIENTS ONLY:

I authorize payment of Medicare benefits to Advantage Physical Therapy for services rendered, and I authorize the release of medical information to CMS (Centers for Medicare and Medicaid Services) and/or its agents.

SIGNATURE

DATE