Flat Rock Physical Therapy for Pain
Patient Information

Date_____

Patient_____Age_____Birthdate_____
First Middle Last
Mailing Address_____

_____

Home Phone_____ Work Phone_____Cell Phone_____
Social Security #_____
Email _____
Employer_____ Occupation_____
Who referred you?_____
Name of general physician_____
In case of emergency who should we contact?
Name_____Phone_____ Relationship_____

INSURANCE INFORMATION

Medicare? YES___ NO___ #_____
Group or Private Health Insurance?_____
Policy or Group#_____Claim or ID#_____
Address_____Phone #_____
Secondary Insurance?_____

Did your accident occur while at work?_____ if yes, complete job injury information
Were you involved in an auto accident?_____ if yes, complete auto accident information

AUTO ACCIDENT INFORMATION

Date_____ Time_____ From what direction were you hit?_____
Location_____Were you the driver?_____
Description of accident_____

_____

Attorney's name and p hone #_____

JOB INJURY INFORMATION

Date of injury_____ Time_____ Reported to employer?_____
Description of accident_____

Flat Rock Physical Therapy
Patient History Form

Name_____ Date_____

Please list any medical conditions you have now, or have been treated for in the past (heart conditions, stroke, cancer, osteoporosis, metal implants, pacemaker)_____

_____

_____

Are you pregnant?_____

Please describe the onset of your pain/symptoms, include date of injury/surgery, how/when symptoms began)._____

_____

_____

_____

Describe what activities, movements or positions make your symptoms/pain Worsen:_____

_____

Improve:_____

_____

Please list all past injuries, surgeries, falls or car accidents including childhood starting with the most recent:_____

_____

_____

_____

Please list all medications including vitamins or nutritional supplements you are currently taking:_____

_____

_____

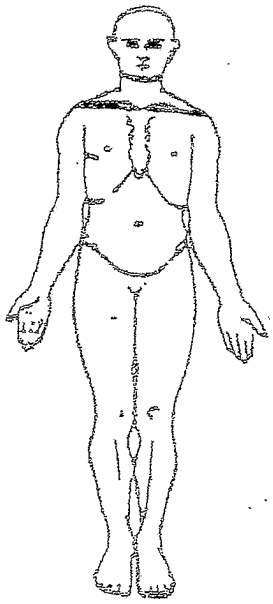
_____

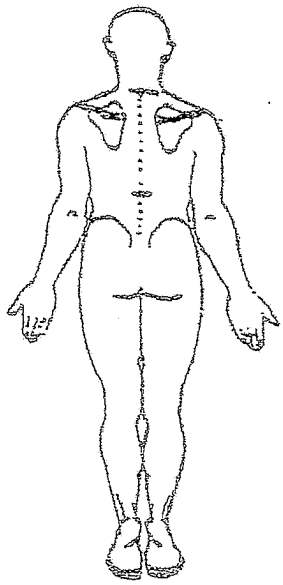
_____

_____

How much water do you drink daily? (Do not include soda, juice, coffee, tea, etc.)_____

Please mark all areas: Pain-(P), Numbness-(N), Weakness-(W)





Have you received prior treatment? Yes_____ No_____
What type?

_____

_____

Did you have testing done? (X-rays, MRI, CT, etc.) What were the results?

_____

_____

Flat Rock Physical Therapy For Pain

Consent for Treatment

I, the undersigned, a patient at Flat Rock Physical Therapy, LLC, do hereby authorize Eddie Maynor, P.T., and whoever he may designate as his assistant to administer treatment as is necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy Flat Rock Physical Therapy will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Flat Rock Physical Therapy, LLC. I am ultimately responsible for all payment of all services rendered, unless otherwise provided by law.

Deductibles/Percentage Pay and/or Co-Payments

Co-Payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the due date on the invoice. Patients are to keep payments current.

Cancellation/No-show Policy

I understand that cancellations should be made within 24 hours prior of their scheduled time, unless extenuation circumstances prevent otherwise. A $25.00 fee may be enforced for no shows or late cancellations. By signing below your are agreeing to all the above terms and conditions. Additionally, I confirm that I have received a copy of Flat Rock Physical Therapy's Notice of Privacy Practices.

_____

Patient or Legal Guardian's Signature Date