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| **PATIENT INFORMATION** |
| Last Name First Name Middle Initial |
| Current Address City State Zip |
| Permanent Address City State Zip |
| Birth Date Age Male Female SSN |
| Mobile Phone: Home Phone |
| Chose Clinic Because Dr. Insurance Family/Friend Website Yellow Pages Other |
| Who Referred You? Email Address |
| **INSURANCE INFORMATION** |
| Primary Insurance Policy Holder Secondary Insurance Policy Holder |
| Name NameRelationship to Patient Relationship to PatientDate of Birth Date of Birth |
| **WORK INFORMATION** |
| Employer Work Phone Ext. |
| Occupation Employment Status Full-Time Part-Time Retired Other |
| **AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INSURANCE INFO ALSO)** |
|  Auto Work Compensation Auto Insurance Name |
| Adjuster/Claim Manager Phone Ext. |
| Address |
| City State Zip |
| Claim # Accident Date State Accident Occurred |
| **ATTORNEY INFORMATION** |
| Name Phone Ext. |
| Address |
| City State Zip |
| **EMERGENCY CONTACT INFORMATION** |
| Name of Local Friend/Relative Relationship to Patient |
| Cell Phone Work Phone Ext. Home Phone |

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| **HAVE YOU EVER BEEN DIAGNOSED AS HAVING AND OF THE FOLLOWING CONDITIONS?** |
|  | **YES** | **NO** |  | **YES** | **NO** |  | **YES** | **NO** |
| Cancer |  |  | Diabetes |  |  | Depression |  |  |
| Heart Problems |  |  | Asthma |  |  | Hepatitis |  |  |
| CHF |  |  | Tuberculosis |  |  | Stroke |  |  |
| Emphysema |  |  | Thyroid Problems |  |  | Kidney Disease |  |  |
| Bronchitis |  |  | Anemia |  |  | Rheumatoid Arthritis |  |  |
| Multiple Sclerosis |  |  | Epilepsy |  |  | Osteoarthritis |  |  |
| Allergies |  |  | Osteoporosis |  |  |  |  |  |

Are you currently pregnant? Yes No List Allergies:

**Do you have a pacemaker? Yes No**

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| **PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED, INCLUDING THE APPROXIMATE DATE AND REASON FOR THE SURGERY OR HOSPITALIZATION:** |
| **Date** | **Surgery/Hospitalization** | **Reason** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list the medication(s) you are currently taking, including pills, injections, and/or skin patches:



Please indicate areas of pain and discomfort (on the figures above) using the following symbols:

/// = Pain \*\*\* = Numbness, no feeling at all +++ = Tingling, asleep, abnormal feeling

Please rate your pain on a scale of 0 to 10: /10 At Highest /10 At Lowest



I authorize my insurance benefits be paid directly to JET Physical Therapy, LLC and I understand that I am financially responsible for any balance. I also authorize JET Physical Therapy, to release any information to process my claims.

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 **PAITENT/GUARDIAN SIGNATURE DATE**