Date: ___/___/_____

Last Name: _____ First Name: _____

Address: _____ Apt or PO Box: _____

City: _____ State: _____

Zip: _____ DOB: ___/___/_____

Phone Numbers

Home Phone: (____) ____ - _____ Email: _____

Work Phone: (____) ____ - _____ Social Security: ____-____-_____

Cell Phone: (____) ____ - _____

Emergency Contact

Last Name: _____ First Name: _____

Phone: (____) ____ - _____

Relationship: _____

Employer

Name: _____

Address: _____ Suite of Office Number: _____

City: _____ State: _____

Zip: _____

Problem

Problem Description: _____

Referred by: _____

Referral Information: _____

Date of Onset: ___/___/_____

Primary Insurance

Insurance: _____ ID Number: _____

Group Number: _____ Claim Number: _____

Deductible: _____ Max Annual Benefit: _____

Copay: _____ Coinsurance: _____

Subscriber Information

Subscriber Name: _____ Subscriber Relation to Patient:
☐Self ☐Spouse ☐Parent ☐Other

Subscriber Date of Birth: ___/___/_____

Secondary Insurance

Insurance: _____ ID Number: _____

Group Number: _____ Claim Number: _____

Deductible: _____ Max Annual Benefit: _____

Copay: _____ Coinsurance: _____

Subscriber Information

Subscriber Name: _____ Subscriber Relation to Patient:
☐Self ☐Spouse ☐Parent ☐Other

Subscriber Date of Birth: ___/___/_____

Have you or a family member ever been treated at Professional PT? ☐Yes ☐No
If yes, which location? _____
Patient's Name: _____
Have you had P.T.,O.T. or Chiropractic treatment this year? ☐Yes ☐No
if yes, which one and for how long? _____
Have you had PT for this condition?
if yes, for how long?_____

For Medicare Patients Only:
Have you had any home care services?
If yes, when will you be fully done with home care?_____
Do you have a home care discharge letter?

For Student Athletes Only:
What sports do they play?_____
If yes, what date were they hurt? ___/___/_____
Were they hurt at school or on a league?
Was the school or league paperwork filed?
Name of School or League:_____

Motor Vehicle Accident Injuries
If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in?
_____

In an ongoing effort to provide our patients with great customer service and the latest information regarding all of our client services you may periodically received emails from our company and its affiliates. If you prefer NOT to get these emails please check the box below:
☐***Opt out of Email News Letter***

Patient or Guardian Agreement:

☐ I authorize release of information requested by my insurance plan for payment.
☐ I understand that I am responsible for any balance due.
☐ I, the undersigned, do hereby agree and give consent for Professional Orthopedic & Sports Physical Therapy to furnish medical care and treatment.
☐ **CONSENT TO TREATMENT**: I consent to receive outpatient rehabilitation therapy services and ancillary services thereto as deemed necessary. I am aware that the practice of rehabilitation therapy is not an exact science and I acknowledge that no guarantees have been made to me regarding treatments, results or outcomes. In conjunction with my care, I consent to allow the use of filming devices such a photographic images for purposes of enhancing my care and I consent to allow transmittal of such images to me and/or my treating physician via email or text.
Signature of Patient or Guardian: _____ Date ____/____/_____

Notice of Privacy Practices:

☐ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)
Signature of Patient or Guardian: _____ Date ____/____/_____