ADVANCED PERFORMANCE
Physical Therapy & Rehabilitation

Caleb Stewart, MPT, DPT, OCS

Patient Name _____ Home phone _____
Last First Middle
Cell phone_____
Address _____ Work phone _____
Street Apt

_____
City State Zip Code

Marital Status: Single ____ Married ____ Other ____ Social Security number _____
Sex: Male ____ Female ____ Date of Birth _____ Age _____
Referring Physician_____ Physician Address _____
Date of Injury: _____ Next appointment with referring Dr. _____
Parent/Guardian Name (if patient is under 18) _____
Address(if different than above)_____
Emergency Contact: _____
Name Phone (inlcuding area code)

_____
Address City State Zip Code

CURRENT EMPLOYER INFORMATION

Employer Name _____ Phone _____

Address _____

ATTORNEY INFORMATION

Have you retained an attorney? Yes ____ No ____

Attorney Name _____ Phone _____
Address _____

WORKER'S COMPENSATION INFORMATION

Employer and Occupation at time of injury _____

Worker's Compensation Carrier _____ Claim # _____
Address _____ Phone _____

Brief Medical History

Type of Injury to be treated _____ Date of onset _____
Have you had physical therapy for the present condition? Yes____ No ____
If yes, where? _____ When? _____

Have you ever had any problems with the following?

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
DIABETES			PACEMAKER			PREVIOUS SURGERY		
PREGNANCY			METAL IMPLANTS			NEUROLOGICAL		
SEIZURES			HIGH BLOOD PRESSURE			NERVOUS DISORDER		
CANCER			HEART ATTACK/DISEASE			X-RAY/MRI		
BOWEL ISSUES			KIDNEY PROBLEMS			KNOWN ALERGIES		
HIV/AIDS			PULMONARY/LUNGS			Communicable Disease		
HEPATITIS			BLADDER/INCONTINENCE			OTHER:		

If you answered yes to any of the above conditions, please explain and give approximate dates: _____
_____
_____

Have you ever used or are you currently using any illicit drugs? Please list _____
Please list any medications you are currently taking and the condition for which you are taking them: _____
_____
_____

PATIENTS WITH NO INSURANCE OR PRIVATE MEDICAL INSURANCE
As a courtesy to you, we will bill your insurance, provided we have the necessary forms and information. Should you have a co-payment, deductible or balance on your account, the remaining balance due uponn receipt of your statement for the date of service. If you have any questions regarding this policy, please inquire the front desk for copy of general policies and procedures.

_____

Signature of responsible party **Date**

PATIENTS WITH ANY HMO COVERAGE

HMO coverage generally requires prior apptoval from Utilization Review for our services to be covered. Visits may or may not be covered, depending on what utilization review and your physician deem necessary. There is also an expration date assigned to approved visits indicating when the visits must be completed. Any therapy that you receive which has not been approved is your financial responsibility. Please refer to the Verification of Benefits form provided.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize the release of any medical information necessary to process this claim and the payment of medical benefits to Advanced Performance Physical Therapy for services rendered. I also request payment of government benefits either to myself or to the party who accepts this assignment.

_____

Signature of responsible party **Date**