FALLON
PHYSICAL THERAPY

Patient Information

Name:_____ DOB:_____

Address:_____ SSN(for billing):_____

Phone:_____ Email:_____

Employer/Occupation:_____

Name of Spouse/Guardian:_____ Physician: _____

Emergency Contact:_____ Ph:_____

Primary Insurance

Insurance Company:_____ Insured Employer:_____

Name of Insured:_____ Insured ID Number:_____

Group Number:_____

Secondary Insurance

Insurance Company:_____ Insured Employer:_____

Name of Insured:_____ Insured ID Number:_____

Group Number:_____

Reason for today's visit: _____

- ☐ New Injury:_____
- ☐ Old Injury:_____
- ☐ Chronic Pain:_____
- ☐ Imaging Completed? **X-Ray / MRI / CT SCAN**
- ☐ Surgery:_____ Date:_____ Follow Up:_____
- ☐ Worker's Comp - Injury Date:_____

Has your complaint **improved / worsened / stayed the same** with time?

Goals/expectations of treatment:_____

Current medications:_____

Daily activities affected:_____

Check any of the following that apply to you:

- ☐ Alzheimer's Disease
- ☐ Cancer:_____
- ☐ Diabetes Type **I / II**
- ☐ High Blood Pressure
- ☐ Previous surgeries: List below
- ☐ Fracture/Suspected Fracture
- ☐ Osteo/Rheumatoid Arthritis
- ☐ Heart Disease/Chest Pain
- ☐ Breathing Problems
- ☐ Circulation Problems
- ☐ Fainting or Dizziness
- ☐ Pregnant/Possibly
- ☐ Headaches
- ☐ Stroke/Head Injury
- ☐ Fibromyalgia

_____

_____

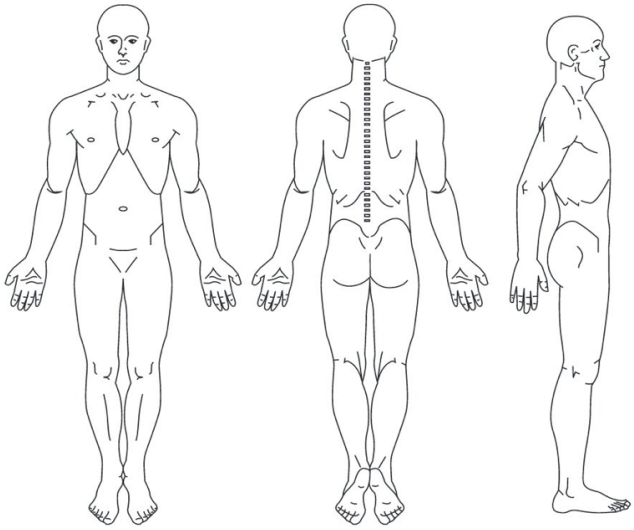
Are you in pain today? Yes / No

Rate your pain on the following scale: (circle one)

Today:	None	0	1	2	3	4	5	6	7	8	9	10 worst possible
At worst:	None	0	1	2	3	4	5	6	7	8	9	10 worst possible
At best:	None	0	1	2	3	4	5	6	7	8	9	10 worst possible

Please mark the following pain diagram:

X for sharp pain **O** for dull ache **///** for burning pain ******* for numbness or tingling



I hereby authorize payment of medical benefits billed to my insurance to FPT. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. In the event this account is assigned to an outside agency for collections, I agree to pay all attorney's fees, court costs, and charges of commission up to 50% with or without suit, which may be assessed by a collection agency retained to pursue the matter.

Signature of Patient or Legal Representative Date

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and full disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.
- The Patient has the right to restrict the use of their information but the Practice does not have to agree with those restrictions.

Patient or Legal Guardian Signature Date