THE PEREZ INSTITUTE
FOR PHYSICAL THERAPY & WELLNESS

PATIENT INFORMATION

Date: _____ Referring MD: _____

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City/State/Zip: _____

Home Phone: (____)_____ Cell Phone: (____)_____

Email: _____

Occupation: _____

Employer Name: _____

Address:_____

City/State/Zip: _____

Work Phone: (____)_____

Gender: Male _____ Female _____

Marital Status: Single ____ Married ____ Other ____

Emergency Contact Name: _____

Phone #: (____)_____ Relationship: _____

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Past Medical History Form

Patient Name: _____ Date: _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ___/___/____

Date of injury / onset: ___/___/____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury ☐ Injury related to falling

☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other: _____

☐ Unknown cause ☐ Athletic/ recreational injury _____

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes			Allergies to Aspirin		
Chest Pain/Angina			Allergies to Heat		
High Blood Pressure			Allergies or Poor Tolerance to Cold		
Heart Disease			Other Allergies		
Heart Attack			Hernia		
Heart Palpitations			Seizures		
Pacemaker			Metal Implants		
Headaches			Dizziness/ Fainting		
Kidney Problems			Recent Fractures		
Are you pregnant?			Surgeries		
Cancer			Skin Abnormalities		
Bowel/ Bladder Abnormalities			Sexual Dysfunction		
Urine Leakage			Nausea/ Vomiting		
Asthma/ Breathing Difficulties			Ringing in your ears		
Liver/ Gallbladder Problems			Rheumatoid Arthritis		
Smoking			Osteoarthritis		
Stroke/ CVA/ TIA			Special Diet Guidelines		
Blood Clotting Disorder			Hypoglycemia		
Acute Thrombosis (blood clot)			Recent Eye Surgery		
Osteoporosis			Other		

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

_____

_____

_____

_____

_____

_____

_____

Is there any other information regarding your health history we should know about?

_____

_____

_____

Please list what medications you are currently taking:

_____

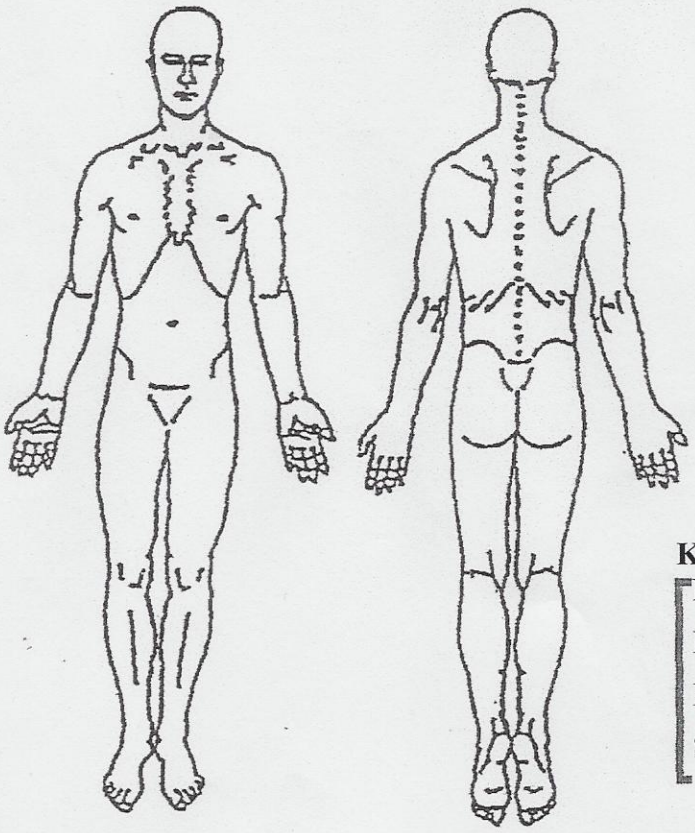
_____

_____

_____

Do you participate in any sports or exercise programs on a regular basis? ☐ Yes ☐ No

If you are having pain, please rate it on a scale from 0 to 10.
(With 0 being no pain and 10 being the worst pain possible: _____



KEY:

Numbness ====

Burning oooooo

Dull Pain xxxxxx

Sharp Pain //////////

_____ _____ _____

Patient's Signature Date Signature of Guardian (If under 18)

_____

Therapist's Signature

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CONSENT TO TREAT

I acknowledge the communication and description of my condition/diagnosis, presenting signs and symptoms, pertinent evaluation findings, contraindications and precautions to treatment, expected benefits of treatment, and reasonable alternatives to treatment when applicable by my clinician. I further acknowledge my consent to receive treatment was voluntary and obtained following my initial evaluation that was performed for the determination of the appropriateness of my plan of care/ treatment program.

I understand that I have the right to ask questions and receive adequate response to my questions at any time during the course of my care; and that I can terminate treatment at any time I wish to discontinue.

Patient Name (print): _____

Patient Signature: _____

Patient Guardian (if under 18): _____

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Statement of Financial Responsibility

Patient Name:_____ Date:_____
Account #:_____

The Perez Institute for Physical Therapy & Wellness appreciates the confidence you have shown in allowing us to provide for your physical therapy needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contact with your insurance carrier. Your payment is due at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy beyond your approved period, you will be responsible for your account balance in full.

Your Primary Insurance coverage information was verified as the following:

Name of Insurance Company:		Visit Limit:
Insurance will cover % of charges:	_____% Insurance	_____% Patient Responsibility
Deductible per year:	$_____, of which	$_____ has been met
Out of pocket:	$_____, of which	$_____ has been met
Co-pay of: $_____	____Each visit	____Eval only ____Eval & Re-eval only

Your Secondary Insurance Coverage information was verified as the following:

Name of Insurance Company:_____
Benefits:

I have read the above policy regarding my financial responsibility regarding the physical therapy and wellness services provided to the above named patient or me. I authorize my insurer to pay any benefits directly to The Perez Institute for Physical Therapy & Wellness. I agree to pay the full and entire amount of all bills incurred by me or the above named patient, and if applicable, the amount due after payment has been made by my insurance carrier.

Signature: _____ Date:_____
(Relationship to patient: self guardian other:_____)