



# ADVANTAGE

PHYSICAL THERAPY & WELLNESS P.C.

## Patient Information

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First Middle

Name you wish to be called: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

E-Mail \_\_\_\_\_ Is it okay for us to contact you by E-mail  Yes  No

Patient's Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Doctor (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Next Dr. Appt: \_\_\_\_\_

How did you hear about us?

Radio  Buzztown  Facebook  Friend/Family \_\_\_\_\_  Advanced Massage Therapy

Phone Book: Circle one please (Redbook/ Dex)  Website  Other \_\_\_\_\_

### Person to notify in case of emergency:

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

## Responsibility Information

Who will be primarily responsible for the bill? \_\_\_\_\_

Will you be using insurance? Name of company \_\_\_\_\_ ID \_\_\_\_\_

Current Complaint: \_\_\_\_\_ Date of Injury or Onset: \_\_\_\_\_

Is your current condition related to:

WORKER'S COMP  AUTO ACCIDENT  OTHER ACCIDENT  N/A

Please check if you have, or have had any of the following:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/Pins
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramping
<input type="checkbox"/>	<input type="checkbox"/>	Back/Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Tendon Tears
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Possibly or currently Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Tendinitis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Wear Orthotics

Have you had any major injuries or surgeries in the last 5 years?  Yes  No If yes, when and for what?

---

You're your current stress level on a scale of 1-10 \_\_\_\_\_

Where do you experience stress in your body most often?

---

Describe the type and frequency of exercise you do \_\_\_\_\_

---

How often do you stretch? \_\_\_\_\_

**Missed Appointments:** We strive to provide our patients with utmost professionalism and excellence of service. As every effort is made to be on time for our patients, we ask that you extend the same courtesy to us by arriving a few minutes before your scheduled appointment. With the exception of serious emergencies it is expected that you keep all your appointments. **If you need to re-schedule an appointment we require that you provide us with 24 HOURS NOTICE. Unless cancelled or re-scheduled at least 24 hours in advance, our policy is to charge a missed appointment fee of \$25.00.** This charge is not covered by your insurance company and will be billed directly to you.

**Financial Agreement:** In the event we are a participating provider with your insurance company and services are covered, we will accept payment from your insurance company. To expedite claims processing, please provide us with your most recent insurance information and keep us informed of any changes to your insurance or contact information. **Your co-payment or co-insurance responsibility will be collected at the time services are rendered.** Your signature below authorizes this action; you will be billed for any additional patient responsibility once your insurance has responded.

**Patient Release & Information:**

I, the undersigned, hereby request evaluation and treatment by Advantage Physical Therapy and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my rehabilitation to my physician(s).

Printed Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_