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	
□	□	Allergies/Asthma	□	□	Joint Replacement/Pins
□	□	Arthritis/Bursitis	□	□	Muscle Cramping
□	□	Back/Neck Pain	□	□	Muscle/Tendon Tears
□	□	Broken Bones	□	□	Numbness/Tingling
□	□	Chemical Sensitivity	□	□	Possibly or currently Pregnant
□	□	Chronic Pain	□	□	Seizures
□	□	Headache	□	□	Tendinitis
□	□	Heart Attack	□	□	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: _____