# PATIENT INFORMATION

Please Print and Complete ALL Entries

| Today's Date: / / | Referring Physician: | Primary Care Physician: | Date of MD follow up: / / |
|---|---|---|---|

## PATIENT INFORMATION

| Patient's Last Name: | First: | MI | Date of Birth: / / |
|---|---|---|---|
| Street Address: | City: | State: | Zip: |

Patient statement and Billing preference: ❑ Email ❑ USPS

Email:

Appointment Reminder preference: ❑ Call ❑ Text

Cell Ph #: ( )

| Social Security Number: ____ ____ ____-____ ____-____ ____ ____ ____ | Employer: (or subscriber Employer): | Alt phone #: ❑ home ❑ cell ❑ work ( ) |
|---|---|---|

| ❑ Male ❑ Female | Marital Status: | Emergency contact Name: ❑ Parent ❑ Spouse ❑ Friend | Emergency Contact phone #: ( ) |
|---|---|---|---|

How did you **first** hear about us? ❑ Medical provider ❑ Internet ❑ Outside sign ❑ Friend ____________________ ❑ Other ________________

## INSURANCE INFORMATION

**Would you like your insurance benefit amounts for physical therapy reviewed with you? ❑ YES ❑ NO**

| Insurance Company(ies) to be billed: | Policy / Claim ID Number: |
|---|---|

Is the Insurance Primary Subscriber also the patient? ❑ YES ❑ NO *If yes, disregard next line*

| Insurance Subscriber's last name: | First: | Subscriber Date of Birth: / / | Relation to Patient (circle): Parent Spouse/Partner |
|---|---|---|---|

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD (if applicable)

## MEDICAL HISTORY

| Injured Body Part(s): ❑ Right ❑ Left | Dominant ❑ R ❑ L | Date of Injury: _____/_____/______ Date of Surgery: _____/_____/______ | How Injury Happened: (if applicable) |
|---|---|---|---|

Accident related? ❑ Not an accident ❑ Work ❑ Home ❑ School ❑ Other ❑ Auto, Include State where Auto Accident Occurred: ________

List Medications:

Related Past Injuries/Illnesses/Surgeries:

Do you have any of the following? (circle all that apply)

| | | | |
|---|---|---|---|
| Diabetes | Stroke | High Blood Pressure | Are you Pregnant? |
| Heart Disease | Cancer | Epilepsy/Seizures | Bloodborne Infectious Disease |
| Asthma | Arthritis | Polio | Pins of Metal Implants |
| Heart Attack | Pacemaker | Multiple Sclerosis | Numbness or Tingling |

## INSURANCE REIMBURSMENT POLICY

Regardless of your insurance benefit, you are responsible for your bill. Benefits quotes are not a guarantee of payment. By signing this form, you agree to assign benefits to be paid directly to 3Dimensional PT, Inc for the amount of the account.

## TREATMENT AND BILLING AUTHORIZATIONS

The information provided by me is true to the best of my knowledge. I authorize 3Dimensional PT, Inc to treat myself or my dependent. Release of my medical information regarding physical therapy treatment may be provided to my insurance company for the purpose of processing my medical, and also to appropriate medical provider(s) of care for coordination of care.

## PRIVACY PRACTICES SUMMARY

By signing this form, I am acknowledging that I have the option to receive a copy of 3Dimensional Physical Therapy's Statement of Privacy Practices, or have declined to receive a copy. I understand that I can get a copy of the aformentioned Statement of Privacy Practices at any time upon request. The statement explains how we use and dislose your health information. If for payment purposes your insurance company requests a copy of your medical records, we will release the requested records to your insurance company. For optimal treatment, we also share information regarding your injury/illness with your doctor. If for any reason you do not wish for either your doctor or insurance company to have copies of your records, or any party described in our Privacy Practices you must inform 3DPT in writing. 3Dimensional Physical Therapy may also release medical information about you to a family member or a friend involved in your medical treatment or payment of your medical bills. Unless specified, 3DPT may also leave messages at your home/work regarding appointments or if we need you to contact us. By signing below, you are agreeing to the terms described above.

| Patient/Guardian Signature: | Date: |
|---|---|