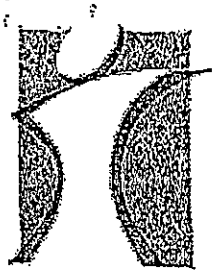


ALLCARE Physical Therapy

3454 Zafarano Drive, Ste A
Santa Fe, NM 87507
(505) 216-5008

PATIENT INFORMATION:

First Name_____ Last Name_____
Preferred Name_____ DOB__/__/____
Home Address_____
Home Phone_____ Cell Phone_____
Email Address_____
Social Security Number (of responsible party)_____
Employer_____
Employer Address_____
Emergency Contact:
Name_____
Relation_____
Phone_____

Patient Gender (Circle one) Male Female Transgender Prefer Not to Say

Referring Physician_____

Have you had any other physical therapy this year? Yes No
If yes, when_____

Insurance Info:

Is this a Work Comp case? Yes No Currently in litigation for your injury? Yes No
Relationship to Insured (circle one) Self Spouse Child Dependent Other_____
Primary Insurance Company _____
Policy Number_____ Group Number_____

Secondary Insurance Company (if applicable) _____
Policy Number_____ Group Number_____

MEDICAL INFORMATION:

Date of onset of symptoms _____

Date of surgery _____

Briefly describe what brings you to PT today _____

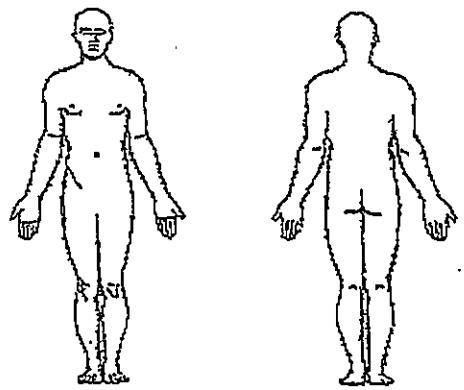
_____

Allergies (please list if applicable)_____ Latex allergy? Y N

Prior Surgeries_____

Currently pregnant? Y N

Pain/ Symptom location (please circle):



Please rate your pain: 0-10

Currently_____

At best_____

At worst_____

Medical conditions: (please check all that apply)

- ☐ Numbness/ tingling
- ☐ Radiating pain
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteopenia/ Osteoporosis
- ☐ Dizziness
- ☐ Nausea/ Vomiting
- ☐ Tripping/ Falls
- ☐ Gastrointestinal issues
- ☐ Weight loss
- ☐ Gout
- ☐ Cancer
- ☐ Change in bowel/ bladder function
- ☐ Headaches
- ☐ Seizures
- ☐ Chest pain
- ☐ Heart issues
- ☐ Pacemaker
- ☐ Other implanted devices
- ☐ other (please explain):_____

Occupation:_____

Recent imaging (within past year):_____

Current medications (names and dosages):_____

_____

I hereby certify that this medical information is accurate to the best of my knowledge

_____ _____

(Signature) (Date)

CONSENT TO TREAT

I, _____ understand that I have been referred for rehabilitative treatment and care to Physical Therapy Center. The Physical Therapy Center will perform an Initial Evaluation and describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Physical Therapy Center provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of Physical Therapy Center. I hereby authorize Physical Therapy Center to furnish my insurance company(s), attorney, or legal representative with all information which said parties may request concerning my present illness or injury. I hereby assign Physical Therapy Center all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Outpatient Rehabilitation. It is understood that any money received from the above-named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Physical Therapy Center for charges not covered by my insurance company. To include copays, deductibles and any other charge as it pertains to physical therapy. I certify by my signature that I have read and agree to this information.

Print Name: _____

Signature: _____ Date: _____