VIEWPOINT PHYSICAL THERAPY

PATIENT INFORMATION

Name: _____ Home Phone #: _____
First MI Last
Date of Birth: _____ Age: _____ Mobile Phone #: _____

E-Mail Address: _____ Work Phone #: _____

Address: _____
Street City Zip
Employer: _____ Occupation: _____
(Parent if patient is minor)
Emergency Contact: _____ Hm or Wk #: _____

MEDICAL INFORMATION

Referring Physician: _____ Primary Physician: _____

Date of Injury or Onset: _____ Date of Surgery: _____ Injured Body Part: _____

How did Injury Occur? _____

List Medications: _____

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

	Yes	No		Yes	No
Diabetes	____	____	Arthritis	____	____
Heart Disease	____	____	Pacemaker	____	____
Heart Attack	____	____	High Blood Pressure	____	____
Stroke	____	____	Epilepsy/Seizures	____	____
Cancer	____	____	Multiple Sclerosis	____	____
Asthma	____	____	Polio/Post Polio	____	____
Pins/Metal Implants	____	____	Infectious Disease	____	____
Head Injury	____	____	Currently Pregnant	____	____

Other Medical History: _____

List Previous Surgeries with dates: _____

List any Allergies: _____

Previous Treatment for this injury/condition: _____

_____

_____

Current Activity Level: _____

INSURANCE/BILLING INFORMATION

Primary Insurance: _____

Subscriber: _____ Relationship: _____ Date of Birth: _____
(Spouse, Dep.)

Secondary Insurance: _____

Subscriber: _____ Relationship: _____ Date of Birth: _____

Subscriber's Employer: _____

Please provide copy of insurance card.

Is this related to an automobile accident? YES/NO PIP Claim #: _____

Insurance Company: _____ Subscriber: _____

Address: _____ Phone #: _____

Claims Manager: _____ Phone #: _____

Attorney's Name and Number (if applicable) _____

Is this injury related to a work accident? YES/NO L & I claim#: _____

Claims Manager: _____ Phone #: _____

In an attempt to serve our patients effectively, we require a 24 hour notice of cancellation except in the case of an emergency or sudden illness. If you do not cancel with sufficient notice or no show your appointment, you may be charged $50 for the visit at the therapist's discretion. If you cancel or no show three appointments, we may choose to discharge you from our services.

REGARDLESS OF YOUR INSURANCE BENEFITS YOU ARE RESPONSIBLE FOR YOUR BILL. We will verify your insurance benefits, but benefits are not a guarantee of payment.

I agree to pay Viewpoint Physical Therapy, PS, for any outstanding balance for services provided whether it is not covered by my insurance, or that is beyond the coverage's of my policy.

I authorize Viewpoint Physical Therapy, PS, to administer any treatment as may be deemed necessary or advisable in treatment or for diagnostic purposes. I understand that this may include physical examination with palpation of soft tissue and bony landmarks, and visual examination of postural alignment in undergarments/shorts.

I authorize Viewpoint Physical Therapy, PS, to release medical information regarding my physical therapy treatment to my insurance company for the purpose of processing my medical claims.

I assign medical benefits to be paid directly to Viewpoint Physical Therapy, PS, for the amount of the account for physical therapy services provided.

I will notify the clinic immediately of any changes in my insurance or address information.

PATIENT/GUARDIAN SIGNATURE: _____Date:_____