



FENTON PHYSICAL THERAPY

Patient Name _____ Date of Birth _____

Address _____ City _____ Zip Code _____

SS# _____ Home Phone _____

Cell Phone _____ E-Mail _____

Patient's Employer _____ Employer Phone # _____

Employer Address _____

Spouse's Name _____ Date of Birth _____ Employer _____

In case of an emergency, who would you like us to contact? _____

Phone# _____ Relationship to you _____

Primary Care Physician _____ Referring Physician _____

Please keep your therapist informed of any appointments you have with your physician.

Date of onset of injury/symptoms/surgery _____

Did you injure yourself while working? ____ Yes ____ No

Did you injure yourself in an auto accident? ____ Yes ____ No

Are you filing a lawsuit or do you intend to in the future? _____ Attorney _____

How did you choose Fenton Physical Therapy for your treatment?

____ My Doctor Friend/Relative ____ Phone Book ____ Other _____

Do you now have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Diabetes			Chronic headaches			Seizures		
High blood pressure			Kidney problems			Metal implants		
Heart problems			Hernia			Cancer		
Pacemaker			Previous surgery			Pregnancy		
Stroke			Arthritis			Other		

If yes to any of the above, please list dates and explain _____

List any medications (including over the counter) you are taking and the condition for which you are taking them _____

I hereby authorize Fenton Physical Therapy to furnish physical therapy treatment as indicated by my physician. Any balances not paid by your insurance company will be billed to you. You, or the insured, are ultimately responsible for all charges including those that have been reduced or deemed not medically necessary by your insurance company. I hereby give permission to Fenton Physical Therapy to release any information regarding my condition, treatment, results of tests and treatment given to my attending/referring physician, insurance carrier, or worker's compensation carrier in accordance with the Fenton Physical Therapy privacy policy. I request payment of authorized benefits be made on my behalf. I hereby authorize release payment directly to Fenton Physical Therapy for services rendered under my care. I understand that I can be held responsible for charges not covered by this assignment. A photocopy of this authorization may be honored as the original.

Signature _____ Date _____