

MRS Physical Therapy

Patient Information Sheet

(please complete both sides of this form)

Appt Date: _____

Appt Time: _____

Account #: _____

Patient Information

Patient FULL LEGAL name _____

Guardian name (if patient is a minor) _____

Address _____ City _____

State: _____ Zip Code _____ Phone _____ Cell Phone _____

Patient's Social Security # _____ Patient's Birthdate _____ Age ____ Sex ____

E-Mail Address _____

Marital Status: (circle) Married Single Other

Employment Status: (circle) Employed Full Time Student Part Time Student N/A

In case of an EMERGENCY, please notify _____ Phone: _____

Physician Information

Referring Physician _____

Primary Care Physician _____

Have you had Home Health (therapy in your home) treatment in the past? YES NO Date: _____

Have you had therapy in the past 12 months? YES NO If yes, where: _____

Insurance Information

Name of **PRIMARY** Insurance Company _____

Primary Insurance ID# _____ Primary Insurance Group# _____

Are you the POLICY HOLDER? Y or N: If you are NOT the policy holder, please complete the fields below:

Policy Holders's Name _____

Policy Holder's Address _____ City _____ ST _____ Zip _____

Policy Holder's Birthdate _____ Policy Holder's Social Security # _____

Name of **SECONDARY** Insurance Company _____

Are you the POLICY HOLDER? Y or N: If you are NOT the policy holder, please complete the fields below:

Policy Holders's Name _____

Policy Holder's Address _____ City _____ ST _____ Zip _____

Policy Holder's Birthdate _____ Policy Holder's Social Security # _____

Name of **TERTIARY** Insurance Company _____

Primary Insurance ID# _____ Primary Insurance Group# _____

Are you the POLICY HOLDER? Y or N: If you are NOT the policy holder, please complete the fields below:

Policy Holders's Name _____

Policy Holder's Address _____ City _____ ST _____ Zip _____

Policy Holder's Birthdate _____ Policy Holder's Social Security # _____

Accident and Claim Information

Is your injury Employment Related? YES NO Date of Injury _____ Claim # _____

Employer: _____ Address: _____

Is your injury related to an Automobile Accident? YES NO Date of Accident: _____

Claim # _____ Adjustors Name: _____ Adjustor Phone: _____

Are you represented by an ATTORNEY? YES NO

Name, Address and Phone of Attorney _____

Marketing Information

How did you choose MRS PHYSICAL THERAPY:

Past patient Friend Radio Newspaper Doctor Other

TREATMENT CONSENT AND INFORMATION RELEASE

The undersigned hereby authorizes consent of treatment and the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to render my treatment, submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

I, (PATIENT) _____ hereby authorize and/or/all of the insurance companies identified above to pay and I hereby assign directly to MRS all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to MRS will be credited to my account in accordance with the above said assignment.

NOTE ** patient information is transmitted and shared via email between company entities and email is not always secure**

(Signature) _____ Date: _____

**MRS Physical Therapy
Past Medical History Questionnaire**

Patient Name _____ Reason for Therapy: _____

Have you ever received therapy for the condition mentioned above? Yes No
If so, when? _____ Treatment Received: _____

Previous Treatment: Successful Unsuccessful

Could you be or are you pregnant? Yes No

Do you now or have you ever had any of the following? Please check all those that apply.

- Arthritis _____ Diabetes _____ Thyroid Problems _____ Osteoporosis _____ Anemia _____
Headaches _____ High Blood Pressure _____ Hypersensitivity to Heat/Cold _____ Concussion _____
Heart Disease _____ Swelling in Ankles _____ Hernia _____ Heart Attack _____ Deep Vein Thrombosis _____
Kidney/Bladder Problems _____ Pacemaker _____ Seizures/Epilepsy _____ Previous Fractures _____
Vascular Disease _____ Metal in Body/Surgical Implants _____ Previous Surgeries _____ Stroke _____
Cancer/Tumor _____ Hearing Loss _____ Asthma _____ Recent Weight Loss or Gain _____ Depression _____
Shortness of Breath _____ Current Infections _____ Anxiety _____ Chronic Cough _____ Tuberculosis _____
Substance Abuse _____ Fainting Spells _____ Hepatitis _____ Other: _____

If you answered "yes" to any of the above, please explain and give approximate date(s):

Do you have any allergies? No Yes If yes, please list _____

Are you presently taking any medications? No Yes
If yes, please list medications, frequency and specify condition: _____

This information is correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ Date: _____