Patient Intake Form

Patient Information	Name:			Age:	Sex: M F
	Address: City: State: Zip:				Marital Status: S M D W
	SSN:	DOB:	Email:		Cell:
Guarantor/ Responsible Party	Name:			DOB:	
	Address: City: State: Zip:				Relationship to Patient:
Spouse/ Emergency Contact	Name:		Relationship to Patient:		
	Address:			Number:	
Referring Physician	Name:			Number:	
Primary Physician	Name:			Number:	
Primary Insurance (Private)	Insurance Co:				
	Member ID:		Group #:		
	Name of Insured:		DOB:	SSN:	
Secondary Insurance (Private)	Insurance Co				
	Member ID:		Group #:		
	Name of Insured:		DOB:	SSN:	

Accident Related ONLY	**Circle One:** **Attorney** OR **Workers Comp**		Date of Injury:
	(Worker's Comp.) Employer Name:	**(Worker's Comp.)** Company Address:	
	Attorney/Adjuster- Name:	**Attorney/Adjuster-** Phone No:	
	Attorney Address/City/State/Zip:		

Assignment Of Benefits	I hereby authorize EXACT Physical Therapy and/or its agents to release any and all information acquired in the course of my examination and/or treatment to the Social Security Administration or its intermediaries, private insurance carriers and/or third-party payers as needed for the processing of this and any related Medicare and/or insurance claims. I permit a copy of this authorization to be used in place of the original and request that benefits be assigned and directly paid to David Biediger, PT EXACT Physical Therapy, Inc for services rendered to me. I understand that I am ultimately responsible for all charges incurred regardless of any and all third-party assignments.		
Signature of Patient/Guarantor	Print Name:	Signature:	Date:

Exact Physical Therapy

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this Facility's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

X _____ X_____

PATIENT SIGNATURE DATE

If a parent, legal guardian, or personal representative of patient is present they may sign for the patient and state their relationship below:

X_____

RELATIONSHIP TO PATIENT

Medical Questionnaire and Treatment Consent

Name: _____ **Date:** _____

Job Title: _____ **Employer:** _____

Work Status: **( ) Full Time** **( ) Part Time** **( ) Disabled** **( ) Unemployed** **( ) Retired**

Age:_____ **Weight:**_____ **Height:** _____ **Dominant Hand:**_____

Family Doctor: _____ **Referring Doctor:**_____

Past Medical History: _____

_____

Current Medications: _____

Are you allergic to: LATEX? _____ **ADHESIVES?** _____ **BIOFREEZE?**_____

Do you smoke:_____ **If yes, how long?** _____ **How much?** _____

Do you drink alcoholic beverages? _____ **How often?** _____

What complaint or difficulty has brought you to physical therapy today?

_____

Date of injury: _____ **Date of surgery:** _____

What previous treatments have you received for this problem? _____

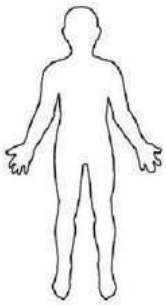
_____

The EXACT Physical Therapy Staff, in an attempt to provide the highest quality of care, requires a 24-hour notice for cancellations and schedule changes. This policy is designed to assist each patient in meeting their goals, and provide each patient with the opportunity to make a schedule that is convenient for them.
If you are unable to provide 24-hour notice, you understand that a **$25.00** penalty will be charged. Special circumstances may allow waiving of this fee.

I realize that my physician has referred me to EXACT Physical Therapy for treatment of my diagnosed condition and I consent to evaluation and treatment by the licensed physical therapists and their ancillary support staff.
I, _____ have read and acknowledge my understanding of the attendance policy of EXACT Physical Therapy and consent to treatment as ordered by my physician.

X_____ **Date:** _____

PLEASE FILL OUT ENTIRE FORM AND INCLUDE ANY PACEMAKER OR HEART IMPLANTS, DIABETES, & BLOOD PRESSURE PROBLEMS



Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the figure to the left where your symptoms/pain is.