



Last Name: _____ First Name: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Other: _____

Date of Birth: ____/____/____ Age: _____ Sex: M F Marital Status: S M W D

Social Security: _____ - _____ - _____ Occupation: _____

Notify in Case of Emergency: _____ Phone: _____

METHOD OF PAYMENT

Private Insurance Medicare Self-Pay: Cash Check Credit Card

If **Private Insurance** or **Medicare**, please provide insurance cards to the front desk for photocopying.

If **Worker's Comp** or **Accident**, please complete:

Work Comp: Date of Injury: _____ Accident: Date of Injury _____ Atty?: Y N

Name of Insurance Company/Attorney: _____

Claim Number: _____ Adjuster: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby instruct and direct my insurance company to pay by check, made out and mailed to **Sundance Physical Therapy, Inc.**, the professional and medical expense benefit allowable under my current insurance policy for services rendered to me or my dependent. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Agreement shall be considered as effective and valid as the original. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information of this sheet and have completed the above information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Subscriber/Beneficiary: _____ Date: _____



ADDITIONAL INFORMATION

MEDICARE PATIENTS:

Have you received any **Physical Therapy or Speech Therapy** since January 1, 2008? Y N

Are you currently (or in the last 60 days) receiving **Home Health Care** through Medicare? Y N

PRIVATE INSURANCE PATIENTS:

As a courtesy, we will report to you your estimated deductible and co-payment amounts from the information received from the insurance carrier. Information we receive from insurance carriers regarding your coverage is NOT a guarantee of benefits or payment. Your insurance plan is your responsibility, so we encourage you to contact them regarding your benefits.

Co-pays are due on the day of service. If you need to make special arrangements regarding payments, please speak to the office manager. For your convenience, we accept cash, checks, and all major credit cards.

ALL PATIENTS:

If you need to cancel an appointment, please do so at least **24 hours in advance**. This allows us time to fill the opening made by your cancellation. **If proper notice is not given, a cancellation fee (up to \$95) will apply and must be paid on or before your next visit.** This fee is your responsibility, and not a reimbursable expense by insurance companies.

How were you referred to us? _____

By signing below, I agree that I have reviewed and understand the information above.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Sundance Physical Therapy, Inc. Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we are providing you, copies of the current notice are available on our website at www.sundancept.com.

I acknowledge that I have received the Notice of Privacy Practices.

Print Name: _____

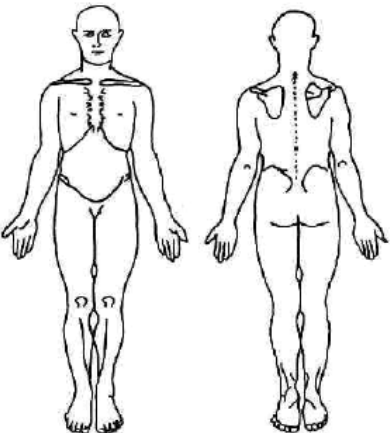
Signature: _____ Date: _____

****Office Use Only**

Patient declined to sign Communication barriers prohibited obtaining the acknowledgement

Other: _____

MEDICAL HISTORY

Circle YES or NO	Circle YES or NO																																																																																			
<p>Have you or any immediate family member ever been told you have...</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th colspan="2" style="text-align: center; border-bottom: 1px solid black;">SELF</th> <th colspan="2" style="text-align: center; border-bottom: 1px solid black;">FAMILY</th> </tr> </thead> <tbody> <tr><td>Cancer</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Diabetes</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>High Blood Pressure</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Heart Disease</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Angina/Chest Pain</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Stroke</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Osteoporosis</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Osteoarthritis</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> <tr><td>Rheumatoid Arthritis</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr> </tbody> </table>		SELF		FAMILY		Cancer	Yes	No	Yes	No	Diabetes	Yes	No	Yes	No	High Blood Pressure	Yes	No	Yes	No	Heart Disease	Yes	No	Yes	No	Angina/Chest Pain	Yes	No	Yes	No	Stroke	Yes	No	Yes	No	Osteoporosis	Yes	No	Yes	No	Osteoarthritis	Yes	No	Yes	No	Rheumatoid Arthritis	Yes	No	Yes	No	<p>Do you have a history of...</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Allergies/Asthma</td><td style="width: 10%; text-align: center;">Yes</td><td style="width: 10%; text-align: center;">No</td></tr> <tr><td>Headaches</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Bronchitis</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Kidney Disease</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Rheumatic Fever</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Ulcers</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Sexually Transmitted Disease</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Seizures</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> </tbody> </table> <p>Are you currently...</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Pregnant</td><td style="width: 10%; text-align: center;">Yes</td><td style="width: 10%; text-align: center;">No</td></tr> <tr><td>Depressed</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Under Stress</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> </tbody> </table>	Allergies/Asthma	Yes	No	Headaches	Yes	No	Bronchitis	Yes	No	Kidney Disease	Yes	No	Rheumatic Fever	Yes	No	Ulcers	Yes	No	Sexually Transmitted Disease	Yes	No	Seizures	Yes	No	Pregnant	Yes	No	Depressed	Yes	No	Under Stress	Yes	No
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<p>In the past 3 months have you had, or do you experience...</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>A change in your health</td><td style="width: 10%; text-align: center;">Yes</td><td style="width: 10%; text-align: center;">No</td></tr> <tr><td>Nausea/Vomiting</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Fever/Chills/Sweats</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Unexplained weight change</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Numbness or tingling</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Changes in appetite</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Difficulty swallowing</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Changes in bowel or bladder function</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Shortness of breath</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Dizziness</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Upper respiratory infection</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> <tr><td>Urinary tract infection</td><td style="text-align: center;">Yes</td><td style="text-align: center;">No</td></tr> </tbody> </table>	A change in your health	Yes	No	Nausea/Vomiting	Yes	No	Fever/Chills/Sweats	Yes	No	Unexplained weight change	Yes	No	Numbness or tingling	Yes	No	Changes in appetite	Yes	No	Difficulty swallowing	Yes	No	Changes in bowel or bladder function	Yes	No	Shortness of breath	Yes	No	Dizziness	Yes	No	Upper respiratory infection	Yes	No	Urinary tract infection	Yes	No	<p>Are your symptoms: (check one)</p> <p><input type="checkbox"/> Getting Worse <input type="checkbox"/> The same <input type="checkbox"/> Improving</p> <p>How are you able to sleep at night? (check one)</p> <p><input type="checkbox"/> Fine <input type="checkbox"/> Some Difficulty <input type="checkbox"/> Only with medication</p> <p>Do you have a problem with...(check all that apply)</p> <p><input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech <input type="checkbox"/> Communication</p> <p>Do you, or have you in the past, smoke tobacco?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, _____ Packs X _____ Years</p> <p>Last tobacco use? _____</p> <p>Do you drink alcoholic beverages?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, _____/week</p>																																															
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<p>Please circle area of pain or discomfort and indicate how long you've experienced the symptoms.</p>																																																																																				

