GLOBAL PHYSICAL THERAPY

ADMISSION FORM

Today's date:				
PATIENT INFORMATION				
Patient's First Name:	Middle Name:	Last Name:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one): Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Patient SSN:	Birth date: / /	Sex: ❑ M ❑ F
Street address:	City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:	
If under 18 y.o., Legal Guardian:		Relation to Patient:		
EMERGENCY CONTACT				
Contact Name:	Phone:		Relation to Patient (circle one): Parent / Sibling / Spouse / Other	
EMPLOYER INFORMATION				
Employer Name:	Patient Occupation:	Employment Status (circle): Full-time / Part-time / Self-Emp. / Retired / Student / None		
Street address:	City:		State:	Zip Code:
Work Phone:				
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Primary Insurance Carrier:	Group #:		ID #:	
Subscriber's Last Name:	First Name:	Birth Date:	SSN:	
Patient's Relationship to Policy Holder: ❑ Self ❑ Child ❑ Spouse ❑ Other:_____				
Occupation (of card holder):	Employer:	Employer address:	Employer Phone:	
Is this patient covered by insurance? ❑ Yes ❑ No				
Secondary Insurance Carrier:	Group #:		ID #:	
Patient's Relationship to Policy Holder: ❑ Self ❑ Child ❑ Spouse ❑ Other:_____				

******If you are receiving or have received a Home Health Service (visiting nurse, therapy, bathing, aide help) in the past 3 months please stop here and speak to the receptionist.**

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ADMISSION FORM (continued)

ADDITIONAL INFORMATION

Date of Injury/Onset Date:	Auto Related: ❑ Yes-State?_____ ❑ No Adjusters Name:_____ Phone:_____	Work Related: ❑ Yes ❑ No	Accident Related: ❑ Yes ❑ No	Diagnosis:

Attorney Involved: ❑ Yes ❑ No Attorney Name: _____ Attorney Address:	Attorney Phone:	Attorney Fax:

Have you had any physical therapy or chiropractic care this calendar year? ❑ Yes ❑ No	Post Surgical: ❑ Yes ❑ No	Description:

How did your current injury occur?

In which areas are you experiencing pain? (please check)

❑ Neck ❑ Back ❑ Arm ❑ Leg ❑ Knee ❑ Shoulder ❑ Elbow ❑ Hand ❑ Buttock ❑ Groin

❑ Thigh ❑ Calf ❑ Ankle ❑ Toes ❑ Other _____

Involved Side: ❑ Right Side ❑ Left Side ❑ Both Sides	Is the pain continuous? ❑ Yes ❑ No	Does the pain wake you up at night? ❑ Yes ❑ No

Please mark the activities that make the pain worse:

❑ Walk ❑ Sit ❑ Stand ❑ Drive ❑ Run ❑ Bend ❑ Lift ❑ Cough ❑ Sneeze ❑ Stairs

❑ Work Duties ❑ Other _____

Please mark other symptoms that you are experiencing:

❑ Numbness ❑ Tingling ❑ Bowel/Bladder Problems ❑ Dizziness ❑ Weakness ❑ Cramps ❑ Nausea

❑ Vomiting ❑ Elevated Temperature ❑ Other _____

What treatments have you had? (please mark)

❑ None ❑ Medications ❑ Brace ❑ Physical Therapy ❑ Aquatic Therapy ❑ Chiropractic ❑ Rest

❑ Other _____ Has it helped?_____

What medications are you currently taking?	Have you had any surgeries? ❑ Yes ❑ No Date: Type:	Have you had any X-rays? ❑ Yes ❑ No Date: Type:

Please mark if you have any of the following:

❑ COPD	❑ Cancer	❑ Hepatitis	❑ Kidney Stones	❑ Rheumatic Fever	❑ High Blood Pressure
❑ Diabetes	❑ Arrhythmia	❑ Renal Failure	❑ Immune Problems	❑ Tuberculosis	❑ Stroke
❑ Asthma	❑ AIDS/HIV	❑ Cardiac Condition	❑ Bleeding Problems	❑ Skin Infection	❑ Ulcers

❑ Other _____

Are you pregnant? ❑ Yes ❑ No	Do you smoke? ❑ Yes ❑ No	Can we contact you via phone, voicemail, email, or direct mail to remind you of your appointment and/or to inform you of our other services? ❑ Yes ❑ No

How did you hear about our clinic? ❑ Friend/Family ❑ Hospital ❑ Insurance ❑ Dr. Referral ❑ Other

Referral's Name: _____

GLOBAL PHYSICAL THERAPY

ADMISSION FORM (continued)

Patient Acknowledgment

Please sign below for release of payment and medical information:

1. I hereby certify that all of the information I provided in this admission form is true to the best of my knowledge.

2. I authorize the release of medical information necessary to process billing, and I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

3. I understand that deductible, co-payment, and co-insurance is required upon each visit or by special arrangement and it is my responsibility to check with the insurance company the specific rates. If my insurance requires a referral or authorization, I am ultimately responsible for obtaining it.

4. In case of Personal Injury, No-Fault, or Third-Party Liability Injury, I authorize Global Physical Therapy, Inc. to recover outstanding medical bills from third-party insurance or any other available insurance. I understand that it is my responsibility to provide Global Physical Therapy, Inc. with information regarding such case/insurance to allow proper billing for services rendered.

   I also give herein my authorization to my attorney and/or liability carrier to pay any outstanding amounts to Global Physical Therapy, Inc. out of any settlement proceeds without further authorization from me.

Patient or Legal Guardian Signature: _____ Date:_____

Print Name: _____ Relation to Patient:_____