

WOODSTOCK PHYSICAL THERAPY & PERFORMANCE INSTITUTE
1816 Eagle Drive, Building 100, Suite C
Woodstock, Georgia 30819

Who may we thank for referring you to us? _____

COMMUNITY AFFILIATION: please circle one: ETOWAH, RIVER RIDGE, CCBOE, JR. EAGLES

PATIENT INFORMATION

LAST NAME: _____ FIRST _____ MI _____ DATE OF BIRTH _____ AGE _____

SOCIAL SECURITY NO: _____ SEX: M / F MARITAL STATUS: SIN / MAR / DIV / WID

ADDRESS: _____ APT: _____ CITY _____ STATE _____ ZIP _____

HOME PH: _____ WORK PH: _____ CELL: _____ OCCUPATION: _____

EMAIL CONTACT ADDRESS: _____

EMPLOYER: _____ ADDRESS: _____

STUDENT STATUS: FT / PT IF A MINOR: MOTHERS NAME _____ FATHERS NAME _____

SPOUSES NAME: _____ DATE OF BIRTH: _____

SPOUSES EMPLOYER (Name and Address): _____ WORK PH: _____

PATIENT RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

EMERGENCY CONTACT (Name and phone): _____ RELATIONSHIP: _____

(IF MINOR) NAME OF MOTHER: _____ NAME OF FATHER: _____

INSURANCE INFORMATION

RESPONSIBLE PARTY (Name and Address): _____ PH: _____

PRIMARY INSURANCE COVERAGE

INSURANCE CO (Name and Address) _____ PH: _____

SUBSCRIBER NAME: _____ SS#: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ POLICY ID#: _____ GROUP #: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE COVERAGE

INSURANCE CO (Name and Address) _____ PH: _____

SUBSCRIBER NAME: _____ SS#: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ POLICY ID#: _____ GROUP #: _____ EFFECTIVE DATE: _____

INJURY / DISORDER INFORMATION

REFERRING DOCTOR: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TYPE OF INJURY/DISORDER: _____

IS THIS INJURY: WORK RELATED / AUTO RELATED / SCHOOL SPORTS / RECREATIONAL SPORTS / OTHER

PLEASE DESCRIBE HOW INJURY/DISORDER OCCURRED: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PAIN/SYMPTOMS:

MY PAIN IS WORSE IN THE: MORNING / EVENING / SAME / FLUCTUATES / IN CONSTANT PAIN

PLEASE LIST ANY ACTIVITIES THAT INCREASE YOUR PAIN/SYMPTOMS:

PLEASE LIST ANY ACTIVITIES THAT DECREASE YOUR PAIN/SYMPTOMS:

WHAT IS YOUR LEVEL OF PAIN RIGHT NOW?

NO PAIN											WORST PAIN EVER
1	2	3	4	5	6	7	8	9	10		

IS YOUR PAIN: DULL / ACHY / BURNING / SHARP / SHOOTING

CONSENT TO TREAT

I do hereby consent to such treatment as prescribed by my physician/physical therapist or by any other physician/physical therapist who may be treating me. I understand that only care appropriate to the setting will be provided and that the above company will, at all times, exercise good faith in this relationship. This consent is intended as a waiver of liability for such treatment with exception of acts of negligence.

SIGNATURE OF PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE SIGNED

PRIVACY NOTICE

I, the undersigned, do hereby acknowledge that I have received a copy of the Privacy Notice regarding the protection of my health information with regard to the legal duties, policies and procedures of Woodstock Physical Therapy. In addition I have been informed as to the company name, address and phone number of the Privacy Officer should I have questions or complaints regarding the privacy practices of Woodstock Physical Therapy.

SIGNATURE OF PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE SIGNED