LINDEN PHYSICAL THERAPY

Patient Name_____ Date of Birth_____

Address_____ City_____ Zip Code_____

SS#_____ Home Phone_____

Cell Phone_____ E-Mail_____

Patient's Employer_____ Employer Phone #_____

Employer Address_____

Spouse's Name_____ Date of Birth_____ Employer_____

In case of an emergency, who would you like us to contact?_____

Phone#_____ Relationship to you_____

Primary Care Physician_____ Referring Physician_____

Please keep your therapist informed of any appointments you have with your physician.

Date of onset of injury/symptoms/surgery_____

Did you injure yourself while working? _____ Yes _____ No

Did you injure yourself in an auto accident? _____ Yes _____No

Are you filing a lawsuit or do you intend to in the future? _____ Attorney_____

How did you choose Linden Physical Therapy for your treatment?

____My Doctor Friend/Relative____ Phone Book____ Other_____

Do you now have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Diabetes			Chronic headaches			Seizures		
High blood pressure			Kidney problems			Metal implants		
Heart problems			Hernia			Cancer		
Pacemaker			Previous surgery			Pregnancy		
Stroke			Arthritis			Other		

If yes to any of the above, please list dates and explain_____

List any medications (including over the counter) you are taking and the condition for which you are taking them_____

I hereby authorize Linden Physical Therapy to furnish physical therapy treatment as indicated by my physician. Any balances not paid by your insurance company will be billed to you. You, or the insured, are ultimately responsible for all charges including those that have been reduced or deemed not medically necessary by your insurance company. I hereby give permission to Linden Physical Therapy to release any information regarding my condition, treatment, results of tests and treatment given to my attending/referring physician, insurance carrier, or worker's compensation carrier in accordance with the Linden Physical Therapy privacy policy. I request payment of authorized benefits be made on my behalf. I hereby authorize release payment directly to Linden Physical Therapy for services rendered under my care. I understand that I can be held responsible for charges not covered by this assignment. A photocopy of this authorization may be honored as the original.

Signature_____ Date_____