



Maumee Physical Therapy & Aquatics Center

Sports Medicine ♦ Aquatic Therapy ♦ Orthopedics ♦ Industrial Rehabilitation

Patient Information (please print)

Patient Name: _____ Home Phone:(_____)_____

Address: _____

Date of Birth: _____ City _____ State _____ Zip _____
Sex (please check) Male _____ Female _____

Social Security Number _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Patient Employer: _____ Work Phone:(_____)_____

Employer Address: _____ City _____ State _____ Zip _____

Responsible Party Information (Parent/ Guardian- if patient is a minor)

Name: _____ Home Phone: (_____)_____

Address: _____

Date of Birth: _____ City _____ State _____ Zip _____
Sex (please check) Male _____ Female _____

Social Security Number: _____ Employer: _____

Employer Address: _____ Work Phone:(_____)_____

Health Insurance Information – Primary

Insured Name _____ Insured Date of Birth: _____ Sex: Male _____ Female _____

Insured ID Number _____ Group Number: _____

Patient's Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insurance Company Name: _____

Insurance Company Address: _____ City _____ State _____ Zip _____

Health Insurance Information-Secondary

Insured Name _____ Insured Date of Birth: _____ Sex: Male _____ Female _____

Insured ID Number: _____ Group Number: _____

Patient's Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insurance Company Name: _____

Insurance Company Address: _____ City _____ State _____ Zip _____

Physician

Referring Physician _____ Primary Care Physician _____

Date of Next appointment with Referring Physician: _____

Symptom/Treatment Information (Mandatory)

Diagnosis or Area of Symptoms: _____ Date of Injury or Onset: _____

Have you received any prior chiropractic, physical, occupational or speech therapy for this condition? Yes ___
No ___

Medicare Patients Only

Have you had medical care in your home in the past 60 days ? Yes ___ No ___

If yes, please give date(month/year): _____

Agency that provided the care: _____

Accident

Are your symptoms related to an accident? Yes ___ No ___ Auto Accident? Yes ___ No ___

Accident Date: _____ State in which accident occurred: _____

Employment –Related Injury (Worker’s Compensation)

Are your symptoms employment related? Yes ___ No ___ BWC Claim # _____ Injury Date: _____

Employer at time of injury: _____

Employer Address: _____
City State Zip

Emergency Contact

Emergency Contact: _____ Emergency Phone: _____

Emergency Address: _____
City State Zip

Relationship to Patient: _____

Authorization for Treatment/Insurance Authorization /Assignment and Guarantee of Account

I authorize treatment as deemed necessary by the therapist. I assign my insurance benefits directly to Comprehensive Rehabilitation Group, Maumee Physical Therapy , or The Spine Care & Rehabilitation Center, whichever is applicable. I understand that unless my signature is affixed, claims cannot be submitted for me and I will be responsible for the charges at the time of service.

I hereby consent to the release of my medical records to the following persons: facility personnel, attending physicians and consultant; any person, firm, government entity, third party payor or managed care organization responsible for all and any part of reimbursement of the patient’s charges.

The responsibility for insurance benefit verification rest with the patient. We will submit the claims to the health insurance companies which have been indicated, however cannot be held responsible for knowing your benefits. We cannot know what, if any, referral or authorization requirements your company may have designed for your policy. All patients are financially responsible for charges incurred regardless of health insurance coverage and it is to the patient’s benefit to become familiar with the limits of his/her insurance benefits as early as possible to facilitate informed treatment decisions.

Patient Signature: _____ Date: _____
(Parent/Guardian if patient is a minor)

OFFICE USE ONLY:

First visit: _____ Diagnosis: _____ Therapist: _____ Witness: _____

