

**NW Sports Physical Therapy, Inc.  
NW Hand Therapy**

**PATIENT INFORMATION**

(Please Print)

Today's date:	Referring Physician:	Primary Care Physician:
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**PATIENT INFORMATION**

Patient's last name:	First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Patient Date of Birth: / /	Age:
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Parent or Legal Guardian last name:	First:	Marital status (circle one): Sgl / Mar / Div / Sep / Wid	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Social Security no.:	Home phone number: ( )
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City:	Zip:	Cell phone number: ( )
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Employer:	Occupation:	Employer phone number: ( )
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E-mail address:

Emergency contact last name:	First: (Spouse or Friend) Circle one	Phone no.: ( )
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Chose clinic because/Referred to clinic by (please check one box):	<input type="checkbox"/> Friend or Family:	Last name:	First:
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<input type="checkbox"/> Dr.	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Postcard	<input type="checkbox"/> Newsletter
<input type="checkbox"/> High School	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Community Seminar
<input type="checkbox"/> Other:					

**MEDICAL HISTORY**

Date of Injury: / /	Date of Surgery: / /	How Injury Happened:	Injured Body Part(s):	<input type="checkbox"/> Left  <input type="checkbox"/> Right
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Accident related? Check which applies:	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home <input type="checkbox"/> Other:
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Are you aware of what your diagnosis is?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List Medications:
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Do you have any of the following?		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Infectious Diseases?
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pins or Metal Implants
<input type="checkbox"/> Asthma	<input type="checkbox"/> Polio	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Are you Pregnant?
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/>
<input type="checkbox"/> Cancer	<input type="checkbox"/> Numbness or Tingling	<input type="checkbox"/>

**CANCELLATION & NO SHOW POLICY**

In an attempt to serve our patients effectively, please attend ALL physical therapy appointments. Cancelled appointments require 24-hour notice. If you CANCEL without notice or NO SHOW a \$25.00 fee will apply. Three cancels or no-shows may result in discharging you from our services and IMMEDIATE notification to your referring physician and if applicable, your claims manager.

**TREATMENT, SUPPLIES, AND BILLING AUTHORIZATIONS**

The information provided by me is true to the best of my knowledge. I authorize Northwest Sports Physical Therapy, Inc. and its affiliates, Northwest Hand Therapy, and Northwest Women's Physical Therapy to treat my dependent or myself. I authorize my insurance benefits be paid directly to the provider of service. I understand that I am financially responsible for any balance remaining for services or supplies rendered if not covered by insurance. Release of my medical information regarding my physical or occupational therapy treatment may be provided to my insurance company for the purpose of processing my medical claim(s). I further assign medical benefits to be paid directly to Northwest Sports Physical Therapy, Inc. for the amount of the account.

Patient/Guardian signature	Date:
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