Orthopaedic Physical Therapy Services

Patient Information

Last Name	First Name	MI	Date of Birth	Soc. Sec. #

Home Address	City	State	Zip	Home phone

Marital Status	Have you been treated here before? If yes, when?	Cell phone

Employer Name	Title/Position

Work Address	City	Zip	Work Phone

Current Medications:

Insurance Name	Ins. Adjuster/Contact	Ins. Phone #

Height	Weight	Do you have a pacemaker? YES or NO	Are you pregnant? YES or NO

History of smoking? If yes, how long?	What is your primary goal for physical therapy?

Emergency Contact Information

Last Name	First Name

Address	City	State	Zip

Home Phone	Work Phone	Relationship

Reason For Today's Visit

Is this injury/condition related to your...

Job YES or NO	**Car** YES or NO	**Home** YES or NO	Other:

Location of injury	Date of injury	Date of surgery

Doctor	Last Doctor's Visit	Next Doctor's Visit

Attorney Information (Name, Address, Phone#)

Authorization of Treatment and Information Release

I further authorize OPTS to release any informationto my Doctor and /or insurance carrier.

Signature:	Printed Name	Date

Parent/Guardian Signature:	Printed Parent/Guardian Name:	Date