NEW PATIENT INFORMATION

Patient Name_____DOB___/___/___M___F___
Address_____
_____ Single___Married___Div___Wid___
Home phone_____Cell phone_____Soc. Sec.#_____
Patient Employer_____Emp. Tel._____
Employer Address_____
_____

Spouse / Parent_____Soc. Sec.#_____
Spouse / Parent Employer_____Emp. Tel_____
Emp. Address_____
Contact in Emergency_____Tel._____
Referring Physician_____Family Physician_____
Workmans Comp_____Motor Vehicle____Other_____Date of Accident_____

Insurance Company_____Policy#_____
Ins. Co. Address_____
_____
Telephone #_____Fax #_____
Contact Person_____Claim#_____
If an attorney is involved, please provide name, address, & telephone_____
_____
Secondary Ins. / Additional Coverage_____
Address_____
Policy / ID numbers_____

While we make every effort to be informed, *it is YOUR responsibility to have current information regarding your physical therapy benefits and be certain all referrals and authorizations are obtained.* Policies change frequently which is why you must be in touch with your insurance company to verify your own benefits, referrals, authorizations, limitations, deductibles, co-pays etc. Information we receive from your insurance company is not a guarantee of payment nor can we be responsible for errors given to us by your company. You are ultimately responsible for any and all expenses not covered by your insurance.

Co-pays are due at the time of your appointment. We do not bill secondary insurances. It is our policy to be reimbursed promptly, and directly from you for any balances due when you receive your statement from our office. If you have secondary insurance it is your responsibility to submit your balance directly to them. Please Initial_____

You will be billed for any balance after your insurance company has paid their reasonable and customary fees which may include, but are not limited to, co-insurance and deductibles. A statement will be sent to you with an explanation of benefits from your primary company for you to submit to your secondary. We appreciate prompt payment within 30 days. A finance charge is computed by a periodic rate of 1-1/2 % / month for balances over 30 days. A collection fee representing one third of the outstanding balance, with a minimum of $50.00, will be added if the account is referred to a collection agency. There will be a $25.00 charge for returned checks.

I understand and agree that I am ultimately responsible for the balance on my account for all services rendered. I authorize Ringwood Physical Therapy to furnish information to my insurance carrier concerning my treatment. I have been made aware of my diagnosis by my physician and consent to treatment by Ringwood Physical Therapy.

DATE_____SIGNATURE_____

RINGWOOD PHYSICAL THERAPY

20 Greenwood Lake Tpke., Ringwood, NJ 07456
PHONE / FAX: (973) 616-0442

Please take time to answer the following medical questionnaire to the best of your ability. This information will be used with your initial evaluation to assist us in formulating your treatment plan. This information will be kept confidential as part of your medical record.

Name:_____ Date:_____

Age:_____ Height:_____ Weight:_____

Occupation:_____ Currently Working? Y N

PAST MEDICAL HISTORY		Have you recently had any of the following symptoms?	
Cancer	Y N	Fatigue	Y N
Heart Disease	Y N	Fever/ Chills/ Sweats	Y N
Chest Pain/ Angina	Y N	Nausea/ Vomiting	Y N
High/Low Blood Pressure	Y N	Weight loss/ gain	Y N
Circulatory Problems	Y N	Difficulty with balance	Y N
Blood Clots	Y N	Numbness/ Tingling	Y N
Stroke/ CVA	Y N	Muscle Weakness	Y N
Lung Problems	Y N	Dizziness	Y N
Tuberculosis	Y N	Headaches/ Migraines	Y N
Asthma	Y N	Difficulty Swallowing	Y N
Rheumatoid Arthritis	Y N	Shortness of Breath	Y N
Kidney Problems	Y N	Fainting	Y N
Diabetes	Y N	Persistent Cough	Y N
Osteoporosis	Y N	Falls	Y N
Multiple Sclerosis (MS)	Y N	Changes in Bowel/Bladder	Y N
Epilepsy/ Seizures	Y N		
Eye Problems	Y N		
Ulcers	Y N		
Hepatitis	Y N		
Parkinson's Disease	Y N		
Lupus/ Rheumatoid problems	Y N		

DIAGNOSTIC TESTS:
MRI Y N Date:_____

X-ray Y N Date:_____

Other:_____ Date:_____

PAST SURGERIES:
_____
_____
_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
_____
_____
_____
_____

ALLERGIES:
_____
_____

For women, are you pregnant or thinking about becoming pregnant? Y N

RINGWOOD PHYSICAL THERAPY

20 Greenwood Lake Tpke., Ringwood, NJ 07456

PHONE / FAX: (973) 616-0442

Please describe your current condition and when it started:_____

What treatment have you received for your current condition?_____

Are your symptoms: Improving Staying the Same Getting Worse

Please describe your recreational activities:_____

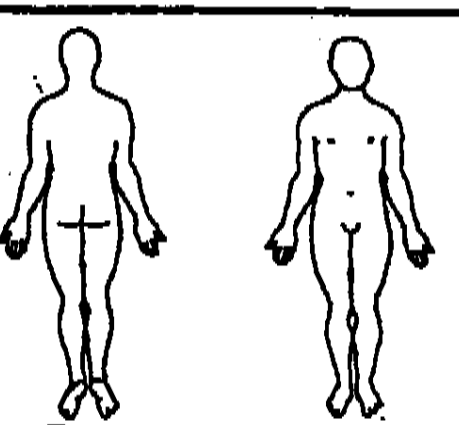
Please describe your work-related activities:_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

Describe pain in box

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
** **Tingling**



My symptoms currently: ☐ **Come and go** ☐ **Are Constant** ☐ **Are constant, but change with activity**

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise
When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise