



## Patient Data Sheet

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Phone Numbers

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cellular: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employers Name and Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employment Status: Full time Part Time Student Retired

Marital Status: Married Single Divorced Widowed

**Emergency Contact** Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Referring Physician** Name: \_\_\_\_\_

Address: \_\_\_\_\_

How Did You Hear About Us: Friend Relative Dr Case Mgr Attorney Phonebook Web Page

Other Advertisement: \_\_\_\_\_

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**Health Insurance-** Medicare/Secondary- BC/BS/MM/PC- MVA-WC-HMO-Private-Keystone

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Date of Accident/Injury: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claim#: \_\_\_\_\_ Policy#: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

If Accident, Please Explain: \_\_\_\_\_

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### **Insurance Authorization and Assignment of Benefits**

I hereby authorize Penn Therapy Associates to furnish information to Insurance carriers concerning my illness and treatment and I hereby assign to Penn Therapy Associates all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(insured or guardian signature)



## Patient Information Form

Name: \_\_\_\_\_

Age: \_\_\_\_\_

DATE OF ONSET: Injury/Problem/Surgery: \_\_\_\_\_

Briefly state previous treatment, if any: \_\_\_\_\_

Do you have now, or have you ever had, any of the following? Please place a check next to the ones that apply to you.

|   |       |                     |       |
|---|-------|---------------------|-------|
| DIABETES  | _____ | ALLERGY TO COLD     | _____ |
| HIGH BLOOD PRESSURE                                   | _____ | OTHER ALLERGIES     | _____ |
| PACEMAKER   | _____ | PREVIOUS SURGERY    | _____ |
| CHRONIC HEADACHES                                     | _____ | SEIZURES            | _____ |
| KIDNEY PROBLEMS                                       | _____ | METAL IMPLANTS      | _____ |
| NERVOUS DISORDERS                                     | _____ | DIZZINESS           | _____ |
| HERNIA  | _____ | CANCER              | _____ |
| ALLERGY TO HEAT                                       | _____ | PREGNANT            | _____ |
| BONE DISORDER   | _____ | OSTEOPOROSIS        | _____ |
| FRACTURES   | _____ | BOWEL PROBLEMS      | _____ |
| BLADDER PROBLEMS                                      | _____ | RECENT WEIGHT LOSS  | _____ |
| PINS & NEEDLES  | _____ | CIRCULATORY DISEASE | _____ |
| PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME | _____ |                     |       |

If YES to any of the above, please explain and give appropriate details: \_\_\_\_\_

Are you presently taking any medications: YES \_\_\_ NO \_\_\_

If YES, please list your medications and for what condition: \_\_\_\_\_

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder? YES \_\_\_ NO \_\_\_\_\_. If YES, please explain the findings as you understand them: \_\_\_\_\_

Is there anything else you think I should know about your general health, or current condition? Please explain and, if necessary, we can talk about it: \_\_\_\_\_



## To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for golf. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're not in pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

**When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice. Please co-operate with us in this regard. We're looking forward to working with you.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Federal Tax ID#: 23-3015044**  
**Physical Therapist: Mark E. Reitz, P.T.**  
**Licensed Physical Therapist**  
**License#: PT-003694-L**  
**Trading As: Penn Therapy Associates, Inc.**

## **MEDICARE PAYMENT AUTHORIZATION FORM**

\_\_\_\_\_  
Name of Medicare Beneficiary (Please Print)

\_\_\_\_\_  
Medicare Number

**I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Penn Therapy Associates, Inc., for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

\_\_\_\_\_  
Medicare Beneficiary's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

authorize