McDONALD PHYSICAL THERAPY NEW PATIENT QUESTIONNAIRE

PATIENT NAME _____
LAST *FIRST* *MIDDiE*

ADDRESS_____

CITY/STATE._____ ZIP CODE _____

HOME PHONE ( ) _____ SS#: _____ SEX: M F

DATE OF BIRTH_____ INSURED'S SS#_____ INSURED'S D.O.B._____

PERMANENT HOME ADDRESS (IF DIFFERENT)._____

CITY/STATE._____ *ZIP CODE*_____

PERMANENT HOME PHONE ( ) _____ CELL PHONE ( )_____

DRIVER'S LICENSE #_____ OCCUPATION _____

EMPLOYER_____ EMPLOYER'S PHONE _____

CITY/STATE_____ ZIP CODE_____

RESPONSIBLE PARTY (self. if over 18 years old)_____ RELATIONSHIP_____

ADDRESS_____ PHONE _____

WHO IS TO BE BILLED: SELF WORKCOMP LEGAL/ACCIDENT INSURANCE OTHER

EMERGENCY CONTACT_____ PHONE_____
NAME AND RELATIONSHIP

REFERRING DOCTOR_____ AREA OF INJURY_____

APPROXIMATE DATE SYMPTOMS BEGAN (INJURY DATE)_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. WHAT PROFESSIONALS HAVE BEEN INVOLVED IN TREATING YOUR CURRENT CONDITION?

2. a. WHAT OTHER HEALTH PROFESSIONALS HAVE YOU SEEN IN THE PAST TWO YEARS?

   b. FOR WHAT CONDITIONS WERE YOU TREATED?

3. PLEASE LIST THE HEALTH CARE PROFESSIONALS THAT Y'OU WOULD LIKE US TO SEND PROGRESS REPORTS TO AND SIGN YOUR NAME IN THE SPACE PROVIDED.

_____
SIGNATURE

1. I AUTHORIZE THE STAFF OF McDONALD PHYSICAL THERAPY, PC, TO CARRY OUT ALL PROCEDURES AS ORDERED BY MY PHYSICIAN ON THE REFERRAL FORM. *(PATIENT OR AUTHORIZED PERSON'S SIGNATURE)*

SIGNED_____ DATE_____

2. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED_____ DATE_____

3. I AUTHORIZED PAYMENT DIRECTLY TO MCDONALD P.T., P.C. FOR PHYSICAL THERAPY SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIRD PARTY PAYERS/MEDICARE AND *PRIVATE INSURANCES).*

SIGNE D_____ DATE _____