

# WINNER PHYSICAL THERAPY, INC.

## PATIENT INFORMATION:

Patient Name \_\_\_\_\_  
(last) (first) (middle initial)

Address \_\_\_\_\_  
Mailing (street) (city) (state) (zip)

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status: S M W D

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ M F

In Case of Emergency Notify \_\_\_\_\_ Telephone: \_\_\_\_\_

Employer \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_  
(last) (first) (middle initial)

Address \_\_\_\_\_  
Mailing (street) (city) (state) (zip)

## INSURANCE INFORMATION:

Medicare # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Insurance Carrier #1: \_\_\_\_\_

Address \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy # \_\_\_\_\_

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

Insurance Carrier #2: \_\_\_\_\_

Address \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy # \_\_\_\_\_

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

Who is your Personal Physician? \_\_\_\_\_

- Who referred you to Winner Physical Therapy, Inc.? 1) Self  
2) Physician \_\_\_\_\_  
3) Friend \_\_\_\_\_  
4) Other \_\_\_\_\_

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Winner Physical Therapy, Inc. to release any information to insurance carriers concerning the examination and/or treatment for myself. I hereby assign to the physician(s), all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(SIGNATURE)

NAME \_\_\_\_\_ SS# \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ MARITAL STATUS - M - S - W - D

OPERATIONS: 1. \_\_\_\_\_ YEAR \_\_\_\_\_  
2. \_\_\_\_\_ YEAR \_\_\_\_\_

DO YOU HAVE A PACEMAKER OR OTHER ELECTRONIC DEVICES -YES -NO

OTHER HOSPITAL ADMISSIONS WERE FOR:

1. \_\_\_\_\_ YEAR \_\_\_\_\_  
2. \_\_\_\_\_ YEAR \_\_\_\_\_

ANY ILLNESS YOU HAVE HAD, EVER: HIGH BLOOD PRESSURE, HEART TROUBLE, DIABETES, PNEUMONIA, SCARLET FEVER, TB, NEPHRITIS (BRIGHT'S DISEASE), EMPHYSEMA, BRONCHITIS, ARTHRITIS, KIDNEY INFECTIONS, NERVOUS OR MENTAL PROBLEMS,

OTHER \_\_\_\_\_

INJURIES: \_\_\_\_\_

UNCONSCIOUS, HEAD INJURY, BAD AUTO ACCIDENT

SMOKE: -YES -NO ALCOHOL: -NO -SOCIAL -EXCESS

THINGS THAT ARE NOW BOTHERING YOU:

GENERAL: FEVER, CHILLS, SOAKING SWEATS, LUMPS, UNACCOUNTABLE WEIGHT LOSS / GAIN

HEAD & EENT UNUSUAL OR CHANGING HEADACHES, DIZZINESS, HEARING LOSS, EAR PAIN, RINGING, DRAINAGE, NOSEBLEEDS, VISION LOSS, EYE PAIN, DRAINAGE MOUTH BLEEDS, SORES, VOICE CHANGE

HEART & LUNGS COUGH, DARK SPUTUM, BLOODY SPUTUM, SHORT OF BREATH, WHEEZING, NEED HIGH PILLOWS, AWAKEN AT NIGHT CHOKING, HEART PAINS, CHEST PAINS, SWELLING FEET, PALPITATIONS

GI: STOMACH PAINS, INDIGESTION, GAS, VOMITING, CONSTIPATION, CHANGED BOWELS, DIARRHEA, YELLOW JAUNDICE, BLOODY STOOLS

GU: BURNING URINE, BLOODY URINE, INFECTION, VD, DIFFICULTY IN STARTING STREAM, DRIBBLING, GET UP TO URINATE \_\_\_\_\_ TIMES AT NIGHT

BJM: STIFF JOINTS, WEAKNESS, JOINT PAINS, BAD BACK, VARICOSE VEINS, MUSCLE PAINS

NEURO: NERVOUSNESS, PARALYSIS, NUMBNESS, FAINTING, STROKE, TENSIONS, TINGLING, WEAKNESS

HEMAT & ENDO BLEEDING, UNUSUAL BRUISING, HAIR CHANGE, SKIN CHANGE  
HEAT/COLD INTOLERANCE, LOSS OF SEX DRIVE

ANY OTHER PROBLEMS YOU HAVE:

# AUTHORIZATION FOR DISCUSSION REGARDING TREATMENT

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

There may be occasions when you want to give another person the ability to discuss your treatment at Winner Physical Therapy with Winner Physical Therapy personnel (appointments, billing, treatment, etc.)

Examples could include:

- a spouse
- a parent (if you are over 18)
- another family member
- your adult child
- a coach
- nursing home representative
- care provider

This authorization will allow discussion only. This does not authorize release of medical records.

I give my permission to Winner Physical Therapy personnel to share information verbally regarding my treatment at Winner Physical Therapy with the following person(s):

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

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

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

Signed \_\_\_\_\_ Date \_\_\_\_\_

**For Staff Use Only:** Permission via phone call

Verbal permission given to: \_\_\_\_\_  
(Employee) (Date)

I give my permission to THE STAFF OF WINNER PHYSICAL THERAPY to administer treatment or procedures which they consider necessary to the benefit of the listed patient

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The undersigned has read the above authorization and understands the same and certifies that no guarantee has been made as to the results that may be obtained.

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time \_\_\_\_\_ AM or PM  
Month Day Year

Signed \_\_\_\_\_  
(Patient or Authorized Person)

Relationship to Patient \_\_\_\_\_