NAME_____SS#_____BIRTH DATE____/____/____AGE_____

ADDRESS_____MARITAL STATUS - M - S - W - D

SURGERIES: 1._____YEAR _____
2._____YEAR _____
3._____YEAR _____
4._____YEAR _____

DO YOU THINK OR ARE YOU PREGNANT? -YES -NO

DO YOU HAVE A PACEMAKER OR DEFIBULATOR? -YES -NO

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

OTHER_____

INJURIES:_____

(CIRCLE) UNCONSCIOUS, HEAD INJURY, BAD AUTO ACCIDENT

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

(CIRCLE) 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:

SODAK PRINTERS, WINNER, SD, 605-842-3151 1/13

WINNER PHYSICAL THERAPY, INC.

825 East 8th Street, Suite 204 PO Box 435

Winner, South Dakota 57580

PATIENT INFORMATION:

Patient Name _____
(last) (first) (middle initital)

Mailing Address _____
(street) (city) (state) (zip)

Person Responsible for Account _____
(last) (first) (middle initital)

Mailing Address _____
(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 _____

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)

SODAK PRINTERS, WINNER, SD, 605-842-3151

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)

SODAK PRINTERS, WINNER, SD 605-842-3151

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

_____

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_____

SODAK PRINTERS, WINNER, SD 605-842-3151