1000 Route 9 North, Suite 202
Woodbridge, NJ 07095
Tel: (732) 750-4900 Fax: (732) 750-4902

Turning Point Sports Physical Therapy

PATIENT INFORMATION FORM (Please PRINT Clearly)

Last Name _____ First Name _____ M.I. _____ Sex _____

Home Address _____ Apt.# _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer Name and Address _____

Social Security Number _____ Date of Birth _____ Age _____ Date of Injury/Onset _____

Referring Physician _____ Phone Number _____

How were you referred to us? _____ Occupation _____

Worker's Compensation (Injured on Job Only): Yes____ No____ Automobile Accident: Yes____ No____

Claim//Policy Number _____ Insurance Agent Name _____

Primary Insurance

Company Name _____ Phone Number _____

Billing Address _____

Name of Insured _____ Relation to Patient _____

Insured's ID Number _____ Group Number _____

Secondary Insurance

Company Name _____ Phone Number _____

Billing Address _____

Name of Insured _____ Relation to Patient _____

Insured's ID Number _____ Group Number _____

Name of person to contact in the case of an emergency: _____ Relation _____

Phone Number _____

I hereby authorize payment of medical benefits billed to my insurance to Turning Point Sports Physical Therapy, LLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time that service is rendered.

_____ _____

Signature of Patient or Guardian Date

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Date:_____

Patient Name: _____

Date of Birth: _____

Date of injury: _____

Where is your problem? (please check all that apply)

☐ Shoulder ☐ Knee ☐ Elbow ☐ Neck
☐ Back ☐ Other _____

Which side(s)? Right / Left / Both

Dominant Arm: Right / Left

Problem(s): (please check all that apply)
☐ Pain ☐ Weakness ☐ Stiffness ☐ Swelling
☐ Instability /giving way / dislocation
☐ Other _____

How did you injure yourself?
☐ No injury – just started hurting
☐ Sports (which sports?) _____
☐ Motor vehicle accident
☐ Work / job

Is there a workers comp claim? Yes / No

Sports level: None / Recreational / Professional

How long have you had symptoms?

_____ Days _____ Months _____ Years

Please briefly describe the injury: _____

_____

Previous treatment(s) for this condition: _____

_____

How severe is the pain? (0 = none, 10 = severe pain)

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Type of pain:
☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Tingling
☐ Numbness ☐ Shooting ☐ Throbbing ☐ Cramps

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Do you experience night sweats? Yes / No

Are you currently working? Yes / No

Limited duty? Yes / No

What makes your problem better? _____

What makes your problem worse? _____

Please describe your current limitations? _____

_____

Have you had any imaging studies?

X-rays: No / Yes date: _____
MRI: No / Yes date: _____
CAT scan: No / Yes date: _____

Allergies to medication(s)?_____

Medical History:

(please circle Yes or No to indicate if you have had any of the following)

Heart problems:	No / Yes
High blood pressure:	No / Yes
Diabetes:	No / Yes
Liver problems, hepatitis:	No / Yes
Kidney disease:	No / Yes
Arthritis:	No / Yes
Rheumatoid arthritis:	No / Yes
Osteoporosis:	No / Yes
Blood clots:	No / Yes
Cancer/tumor:	No / Yes
Pacemaker:	No / Yes

Other? (please use back of sheet as necessary)_____

Did you lose a significant amount of weight in the past few months? Yes / No

Previous surgeries: _____

_____

Current medications: _____

_____

Have you had physical therapy within past year? (for any condition(s)) Yes / No

Habits: Smoking: No / Yes Alcohol: No / Yes

Are you pregnant? No / Yes Due Date _____

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ASSIGNMENT OF BENEFITS

Patient Name _____

Primary Insurance Name _____ Insured Name_____

Policy Number___ _____Group Number_____

Social Security Number _____ Insured Date of Birth _____

Claim # (if applicable): _____

Secondary Insurance Name _____ Policy Number _____

I certify to the best of my knowledge that the information I have given is correct.

I hereby authorize the release of any medical or other information necessary to treat my condition or process my claims to my insurance company. I also authorize payment of medical benefits from my insurance company to be made directly to Turning Point Sports Physical Therapy, LLC at the above address, for services provided. This assignment will remain in effect until I revoke it in writing. I understand that information concerning my condition is confidential and will only be released upon my written consent. I, the undersigned, give Turning Point Sports Physical Therapy, LLC the consent to evaluate and treat me.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my insurance coverage is a relationship between myself and the insurance company.

I understand that my account will become delinquent 30 days after discharge. I understand that a finance charge of 18% per month will be added to the balance until full payment is completed. I will also pay any charges incurred such as collection, court, and attorney fees.

I authorize the use of this signature on all insurance submissions.

Dated this _____ day of _____ , 20____.

Signature of Policy Holder or Responsible Party _____