Patient Information	Name(Last, First, Middle)			Age	Sex M F
	Address	City	State	Zip Code	Marital Status S M D W Sep
	SSN	Date of Birth	Home Phone		Cell/Alternate Phone
	E-mail				
	Employer		Work Phone		Occupation
Guarantor/ Responsible Party	Name(Last, First, Middle)			Date of Birth	SSN
	Address	City	State	Zip Code	Relationship to Patient
	Employer	Address	City	State	Zip
Spouse/ Emergency Contact	Name				Relationship to Patient
	Address	City	State	Zip Code	Phone Number
Referring Physician	Name	Address			Phone Number
Primary Physician	Name	Address			Phone Number
Primary Insurance (Private)	Insurance Co	Address/ City/State/ Zip Code			
	Policy #	Group #			Phone Number
	Name of Insured	Date of Birth	SSN		Employer
Secondary Insurance (Private)	Insurance Co	Address/ City/ State/ Zip Code			
	Policy #	Group #			Phone Number
	Name of Insured	Date of Birth	SSN		Employer

On-The-Job Injury	Employer at Time of Injury	Date of Injury:	Workers Compensation Insurance Company
	Name:		Name:
	Address:		Address:
	City, State, Zip:		City, State, Zip:
	County:		Phone:
	Contact Person:		Adjuster:
	Phone:		Adj Phone/Ext:
	TWCC #		Claim#
Accident Related	Are you represented by an Attorney? Yes No Undecided		Date of Injury/ Accident:
	Auto Related: Yes No	Other Accident:	LOP Provided? Yes No
	Attorneys Name	Address/City/State/Zip	Phone Number

Assignment Of Benefits	I hereby authorize Texas Premier Physical Therapy and/or its agents to release any and all information acquired in the course of my examination and/or treatment to the Social Security Administration or its intermediaries, private insurance carries and/or third party payors as needed for the processing of this and any related Medicare and/or insurance claims. I permit a copy of this authorization to be used in place of the original and request that benefits be assigned and directly paid to Texas Premier Physical Therapy for services rendered to me. I understand that I am ultimately responsible for all charges incurred regardless of any and all third party assignments		
Signature of Patient/ Guarantor	Print Name	Signature	Today's Date

Medical History

Patient: _____ **Today's Date:** _____

General Information

1. Is this injury related to? ☐ Work ☐ Car Accident ☐ Other Liability/Potential Lawsuit ☐ Not Applicable

2. Do you have a Primary Care Physician / Family Doctor? ☐ No ☐ Yes
   If yes, have you had an appointment with him / her in the last 12 months? ☐ No ☐ Yes

3. Race/Ethnicity (Please select one):

☐ Hispanic or Latino Origin ☐ Caucasian (White) ☐ Native American ☐ Other

☐ African American ☐ Asian ☐ Eskimo/Inuit ☐ Declined

Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid	Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid
Smoking (including smokeless tobacco)	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Metal implants	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Head injury	☐	☐	☐	☐
Circulation / vascular problems	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Chronic pain / fibro / headaches	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐	Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS / Parkinsons's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐ Spine ☐ Upper Extremity ☐ Lower Extremity

Medical History

Patient: _____ Today's Date: _____

Patient Medication List

Please list ALL medications (including prescription, over-the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration

PATIENT AUTHORIZATION:

Consent for Treatment and Authorization to Release Information

I hereby authorize TEXAS PREMIER PHYSICAL THERAPY, L.L.C., to provide any physical therapy services or related services as deemed necessary by the physical therapist(s). I consent and authorize TEXAS PREMIER PHYSICAL THERAPY, L.L.C., to release all information contained in my medical and financial records, including diagnosis and test results. INITIALS: _____

Acknowledgement of Review of Notice of Privacy Practices

I have been offered a copy of the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. INITIALS: _____

Cancellation and No-Show Policy

TEXAS PREMIER PHYSICAL THERAPY, L.L.C., strives to provide each patient with the highest quality care while accommodating your schedule. Therefore, we reserve specific time-allotments for each patient. It is critical for you to consistently attend your scheduled appointments in order to achieve the goals that you want to achieve.

We respectfully request 24-hours advance notice of any appointment cancellation. If we do not receive advanced notice of a cancellation, our ability to meet the scheduling needs of our other patients is limited. **If you cancel without a 24- hour notice, you will be charged a $25.00 Cancellation Fee.** In addition, if you do not keep your appointments, **your treatment program will be terminated after the second consecutive NO-SHOW or third consecutive CANCELLATION** and your physician will be notified immediately. We recognize legitimate reasons for missing appointments and keep accurate records of these occurrences, but we need your cooperation in contacting our office as soon as possible when you will be unable to keep you appointments.

Worker's Compensation Patients: All cancellations and NO-SHOWS will be documented in your medical record and appropriately reported to your physician, employer and adjuster. **Be advised, every appointment for which you do no show will be reported that same day.** Thank you for your cooperation and consideration of our staff and other patients.

I have read the Cancellation and No-Show Policy of TEXAS PREMIER PHYSICAL THERAPY, L.L.C. I understand its contents and agree to the terms above. INITIALS: _____

Personal Valuable

I hereby release TEXAS PREMIER PHYSICAL THERAPY, L.L.C., and its associates of any and all responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession or brought in by me or anyone with me during my care. INITIALS: _____

Contact Authorization

I hereby authorize TEXAS PREMIER PHYSICAL THERAPY, L.L.C, to contact me and/or a minor under my guardianship via phone, text, or email in regards to my medical care. INITIALS: _____