

Patient Name: _____

Date of Injury: _____

Check the following which apply to your injury:

- work related injury
- fall
- OTHER: _____
- motor vehicle accident
- athletic / recreational injury
- recurrence of previous injury
- cause unknown
- surgery

Have you had any orthopedic surgeries? NO _____ YES _____ If yes, list procedures and dates: _____

Check any of the following medical conditions you have that may interfere with your treatment:

- No known conditions that will affect treatment
- Osteoarthritis
- Cardiovascular Disease
- Allergies (please list) _____
- Other (please list) _____
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2

Are you currently taking medications, either prescribed or OTC? NO _____ YES _____

If yes, please list: _____

Other than your referring physician, have you been treated by any other medical professional for this injury? NO _____ YES _____

If yes, circle one: physical therapist chiropractor massage other: _____

Type of Pain (circle):

Sharp Dull Ache Tingling Numbness Other: _____

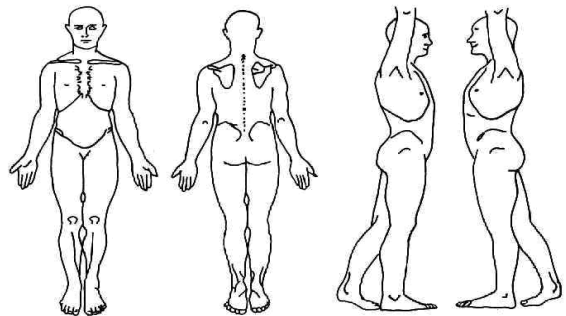
Please list any recreational activities/hobbies that you participate in and how often and for what duration you perform them: _____

Please list goals you would like to achieve during your course of treatment: _____

Rate the intensity of the pain

At Worst: 0 1 2 3 4 5 6 7 8 9 10
Current: 0 1 2 3 4 5 6 7 8 9 10
At Best: 0 1 2 3 4 5 6 7 8 9 10

Please indicate location of symptoms



Signature

Relationship to patient

Date

Which of the following represents the reason you chose SMTC? (Circle all that apply)

- I have been a patient or exercise client here before
- A family member, friend or co-worker has been a patient or exercise client before
- My physician recommended SMTC My school trainer recommended SMTC School: _____
- Case manager Attorney recommended SMTC Workers' Compensation
- Online What Site: _____ Drive by/Live Close By Insurance Plan Website
- I have participated in dance activities at the SMTC studio or was attracted by the Dance Medicine Program
- I was a participant or spectator at an athletic event where SMTC was providing medical services
- Other: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Street Address: _____ City: _____
State: _____ Zip: _____ Date of Birth: ____/____/____ SSN: ____/____/____
Home Phone: _____ Alternate/cell phone: _____
Sex: Male Female Marital Status (circle one): Single Married Domestic Partnership Widowed
Occupation or School: _____ Full-Time Part-Time
Duty Level: Full Light Other _____ Out of Work Since: _____ Return to Work: _____
Emergency Contact Name: _____
Relationship to Patient: _____ Phone Number: _____
May we contact you via email with company updates, patient surveys and/or company newsletters?
YES ___ NO ___ Email Address: _____

INSURANCE AND GUARANTOR INFORMATION

Policy Holder: _____ Date of Birth: ____/____/____ SSN: ____/____/____
Relationship to patient: (circle one) Self Spouse Parent/Guardian
Secondary Insurance Policy Holder: _____ Date of Birth: ____/____/____
Relationship to patient: (circle one) Self Spouse Parent/Guardian
Who should be billed for any balance due (after insurance)?: _____
Is guarantor's address different than patient?: YES ___ NO ___ If yes, please provide below:

LEGAL INFORMATION

Is this a Worker's Compensation case?: NO ___ YES ___ Company: _____
Contact/Case Manager: _____ Phone Number: _____
Employer: _____
Employer Street Address: _____ City: _____
State: _____ Zip Code: _____ Employer Phone Number: _____
Is this a Litigation case?: NO ___ YES ___ Attorney's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Attorney Phone Number: _____ Contact Person: _____
Is this an auto accident?: NO ___ YES ___ Claim# _____
Adjuster's Name: _____ Adjuster's Phone Number: _____

I acknowledge that the information I have provided is true and correct and I am ultimately responsible for payment of all charges incurred for my therapy. If my insurance benefits or any settlement received from litigation is not sufficient to pay for these services, then I personally guarantee payment. I authorize my insurance carrier to make any payment for services rendered to me or my dependent directly to the provider. Any account balance remaining unpaid over six months will be charged a 1.5% service fee unless automatic payment plan is established. Any account remaining unpaid without satisfactory arrangements may be turned over to a collection agency. Should my account be referred to an agency for collection, I agree to pay reasonable collection costs on the unpaid balance. I hereby authorize The Sports Medicine and Training Center, L.L.C. to render treatment to me as ordered by my physician and grant permission to The Sports Medicine and Training Center, L.L.C. to obtain my medical records from my physician. I also authorize The Sports Medicine and Training Center, L.L.C. to release my medical records to my insurance carrier / worker's compensation carrier / third party guarantor as needed to collect payment.

Signature

Relationship to patient

Date