



# MILFORD PHYSICAL THERAPY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 SS# \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Patient's Employer \_\_\_\_\_ Employer Phone # \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

In case of an emergency, who would you like us to contact? \_\_\_\_\_  
 Phone# \_\_\_\_\_ Relationship to you \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

**Please keep your therapist informed of any appointments you have with your physician.**

Date of onset of injury/symptoms/surgery \_\_\_\_\_  
 Did you injure yourself while working? \_\_\_\_ Yes \_\_\_\_ No  
 Did you injure yourself in an auto accident? \_\_\_\_ Yes \_\_\_\_ No  
 Are you filing a lawsuit or do you intend to in the future? \_\_\_\_\_ Attorney \_\_\_\_\_  
 How did you choose Milford Physical Therapy for your treatment?  
 \_\_\_\_ My Doctor \_\_\_\_ Friend/Relative \_\_\_\_ Phone Book \_\_\_\_ Other \_\_\_\_\_

Do you now have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Diabetes			Chronic headaches			Seizures		
High blood pressure			Kidney problems			Metal implants		
Heart problems			Hernia			Cancer		
Pacemaker			Previous surgery			Pregnancy		
Stroke			Arthritis			Other		

If yes to any of the above, please list dates and explain \_\_\_\_\_

List any medications (including over the counter) you are taking and the condition for which you are taking them \_\_\_\_\_

I hereby authorize Milford Physical Therapy to furnish physical therapy treatment as indicated by my physician. Any balances not paid by your insurance company will be billed to you. You, or the insured, are ultimately responsible for all charges including those that have been reduced or deemed not medically necessary by your insurance company. I hereby give permission to Milford Physical Therapy to release any information regarding my condition, treatment, results of tests and treatment given to my attending/referring physician, insurance carrier, or worker's compensation carrier in accordance with the Milford Physical Therapy privacy policy. I request payment of authorized benefits be made on my behalf. I hereby authorize release payment directly to Milford Physical Therapy for services rendered under my care. I understand that I can be held responsible for charges not covered by this assignment. A photocopy of this authorization may be honored as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_