Advanced Rehab and Medical/ 45 Urgent Care
Confidential Patient Data

PATIENT INFORMATION

Today's Date:_____
Name:_____Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____Work Phone: _____ Cell: _____
Email: _____Social Security #:_____ Age:_____
❑ Male ❑ Female Marital Status: ❑ Married ❑Single ❑Divorced ❑Other_____
Name of Spouse or Nearest Relative: _____ Phone:_____
Your Occupation_____ Your Employer: _____
How did you hear about us? _____
Name of Insurance Co.:_____Insured's Employer: _____
Insured's Social Security #:_____ Insured's Date of Birth: _____
Are you covered by more than one insurance company? ❑Yes ❑No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Heart Disease	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	Measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	Stroke
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	tuberculosis
								❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

SURGICAL HISTORY:
1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms (1-10, with 1 being least serious)

1._____ _____
2._____ _____
3._____ _____
4._____ _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑Consistent
WHEN AND HOW OCCURRED? _____

_____
SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: _____
SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND? _____
_____
_____
_____

ARE YOU PREGNANT ❑NO ❑YES ❑MAYBE

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

SOCIAL HISTORY
DO YOU SMOKE? YES ____ NO ____ IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES ____ NO ____ IF YES, HOW OFTEN AND HOW MUCH? _____

ILLICIT DRUGS? YES ____ NO ____ IF YES, DESCRIBE _____

Certification and Assignment
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to Advanced Rehab and Medical/45 Urgent Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsibility for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Please print name of patient or guardian Relationship to Patient