Lawney Physical Therapy, P.C.

5 St. Marks Place, P.O. Box 504, Fort Montgomery, N.Y. 10922
Phone: (845) 859-4110 Fax: (845) 335-5631
Lawneypt@gmail.com

PATIENT HISTORY

NAME: ______________________________________ DATE OF NEXT MD APPOINTMENT: ____________________

Describe briefly the history of your present ACCIDENT, INJURY, ILLNESS OR CONDITION:

Onset Date: ___________

Description:____

____

____

Please list any special concerns, questions or expectations: ____

____

Have you had any physical therapy during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? ______ If yes, please indicate where and when: ____

List **ALL** medications you are currently taking: ____

____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____________________________________

____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.? Describe:

____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible: ____________________________________

____

____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Allergies to latex?	Yes	No
Dizzy Spells	Yes	No	Seizures	Yes	No

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PATIENT/GAURDIAN SIGNATURE: ____DATE: ___/_____/_____

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PATIENT INFORMATION/AUTHORIZATION TO TREAT

PATIENTS NAME______________________________________ DATE OF BIRTH______________ AGE _____

MAILING ADDRESS____________________________________ CITY___________________ ZIP__________

HOME PHONE (_____)_____________________ CELL PHONE (_____)___________________ SEX: M OR F

PATIENT SSN_______-________-___________ DRIVER'S LICENSE#________________________________

PATIENT EMPLOYER____

OCCUPATION____ WORK PHONE (____) _________________

REFERRING PHYSICIAN___________________________ PRIMARY PHYSICIAN_______________________

DATE OF INJURY______________________ DATE OF SURGERY___________________________________

PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP__________________________

FIRST AND LAST NAME____________________________________ PHONE(_____)_______________________

****IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION**:

PARENT/GUARDIAN NAME_____________________________________ SSN_______-________-__________

PARENT/GUARDIAN EMPLOYER______________________________ WORK PHONE(_____)______________

INSURANCE ____ ***please present card @ time of service***

WAS THIS A MOTOR VEHICLE ACCIDENT___________ **IF YES PLEASE COMPLETE THE FOLLOWING**

NAME OF VEHICLE INSURANCE______________________________ PHONE (_____)____________________

NAME OF PERSON INSURED_____________________________ ADJUSTER NAME _____________________

ACCIDENT CLAIM#____________________________

****PLEASE INITIAL THE FOLLOWING:**

_____ **I HEREBY AUTHORIZE LAWNEY PHYSICAL THERAPY, P.C. TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.**

_____ **I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO LAWNEY PHYSICAL THERAPY, P.C.**

_____ **I UNDERSTAND THAT IF MY INSURANCE CO/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT I AM RESPONSIBLE FOR THE BALANCE DUE.**

_____ **I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO LAWNEY PHYSICAL THERAPY, P.C. AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.**

_____ **I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY LAWNEY PHYSICAL THERAPY, P.C. INSURANCE IS BEING BILLED AS A COURTESY. I AM RESPONSIBLE FOR PAYING ANY DEDUCTIBLE OR CO-INSURANCE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

SIGNATURE OF PATIENT/PARENT/GUARDIAN_______________________________ **DATE**_____________