Regional Physiotherapy Centre, Inc.

Name: Mrs/ Ms./ Mr. _____ Date: _____

Address: _____ State: ____ City: _____ Zip: _____

Marital Status: S M D W DOB: _____

Best phone number to reach you at: _____

Emergency Contact: _____ Emergency contact number: _____

Whom may we thank for this referral? _____

Please list previous surgeries and hospitalizations: _____

Please list current medications and dosages:

If you have any problems getting to your appointment, financial, with family members, maintaining your property or handling stress and your feel you need to discuss these or any problems with a professional - please check here: _____

HAVE YOU HAD, BEEN DIAGNOSED AS HAVING, OR CONSULTED A PHYSICIAN FOR ANY OF THE FOLLOWING: (Please check any/all that apply)

( ) Diabetes/Hypoglycemia	( ) Heart Attack	( ) Hemophilia
( ) High Blood Pressure	( ) Respiratory Illness	( ) Stroke/ CVA
( ) Cancer	( ) Previous Head Trauma	( ) Prev. Back Problems
( ) Sensory disturbance	( ) Joint Problems	( ) Heat Stroke or illness
( ) Arthritis	( ) Pacemaker	( ) Metal Implants
( ) Acute Infections	( ) Convulsions	( ) Hepatitis
( ) Allergies	( ) HIV / AIDS	( ) Other: Give Details
( ) Latex Sensitivity	( ) Hot or cold intolerance	

Acknowledgement, Authorization and Assignment

I have viewed a copy of Regional Physiotherapy Centre, Inc. Notice of Privacy Practices and it has been explained to me as required by the Health Insurance Portibility and Accountability Act (HIPAA). I authorize Regional Physiotherapy Centre, Inc. and its agents to release any information including my protected health information to any insurance company or billing company and its agents as is neccessary to determind benefits. I authorize payment to be made by my insurance carrier directly to Advanced Fitness and Therapy for services rendered.

_____ _____

Patient's Signature Date Witness Date