PATIENT INFORMATION—INDIANAPOLIS REHABILITATION -- *(front & back)*

Patient's Full Name_____**Date**_____

ADDRESS_____ **CITY**_____ **STATE** _____ **ZIP** _____

GENDER _____ **AGE** _____ **DATE OF BIRTH**_____ **HOME/CELL PHONE** _____

EMPLOYER_____ **FULL TIME**_____**PART TIME**_____

BUSINESS ADDRESS_____**WORK PHONE**_____

SOCIAL SECURITY #_____ **MARITAL STATUS: M**___ **S**___ **D**___ **W**___

Name of Spouse/Significant other_____ **DATE OF BIRTH**_____

Employer (Spouse) _____**Full Time** ___ **Part Time** ___ **Phone** _____

Business Address (Spouse)_____**Social Security #**_____

IF MINOR: PARENTS' NAMES & ADDRESSES & PHONE NUMBERS:
*Mother's Name*_____ *Father's Name* _____
(Mother's Address)_____
(Father's Address)_____
Parent Cell/Phones: **(MOM)** _____ **(DAD)** _____
MOTHER'S EMPLOYER & BUSINESS ADDRESS _____
_____ (Work Phone)_____
FATHER'S EMPLOYER & BUSINESS ADDRESS _____
_____ (Work Phone) _____

TYPE OF HEALTH INSURANCE: _____
Does your insurance require prior authorization? YES _____ NO _____
Who will be responsible for this bill? _____
**** PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST TO MAKE A COPY****

Referring Physician:_____ **Next Physician Appointment:** _____
DESCRIBE THE PROBLEM OR INJURY THAT NECESSITATES SEEING THE PHYSICAL THERAPIST TODAY? _____
Were you injured? _____ Date of injury? _____ Other accident? _____

I authorize release of information and/or payment of medical benefits to INDIANAPOLIS REHABILITATION–DAVID L. CROSS for any services furnished me by that provider. I realize that I will be responsible for any unpaid portion of this bill.

_____
Insured or Authorized Person

MEDICAL INFORMATION: *check next to any illnesses you may have had*

_____anemia	_____hepatitis	_____seizures
_____asthma	_____heart disease	_____rheumatic fever
_____bleeding tendencies	_____hernia	_____rheumatoid arthritis
_____bronchitis	_____HIV or AIDS	_____osteoarthritis
_____cancer/tumors	_____high blood pressure	_____stomach trouble
_____diabetes	_____liver disease	_____ulcers
_____epilepsy	_____kidney disease	_____tuberculosis
_____eye disease	_____meningitis	_____urinary tract infections
_____heart murmur	_____lung disease	_____circulation problems

CHECK PREVIOUS TREATMENT OR MEDICATION:

_____alcoholism/fetal alcohol syndrome	_____iron deficiency
_____special diet (explain)	_____vitamins
_____heart medicine, digitalis, quinine	_____thyroid
_____cortisone or steroids	_____narcotics
_____insulin or diabetes	_____blood thinners
_____hormone therapy	_____sleeping pills
_____tranquilizers/sedatives	_____Borderline personality
_____frequent enemas or laxatives	_____anti-depressants
_____ADD/ADHD (attention deficit/hyperactivity)	_____Schizophrenia
_____ASD (autism spectrum disorder--meds)	_____Bipolar Disorder

OPERATIONS

TYPE	*MONTH/YEAR*	*HOSPITAL*
_____	_____	_____
_____	_____	_____
_____	_____	_____

FRACTURES

_____ _____

_____ _____

HEIGHT_____ WEIGHT (pounds) _____ BMI (Body/Mass Index) _____

LIST THE NAME AND DOSAGE OF MEDICATIONS TAKEN DAILY:

_____ _____

_____ _____

PLEASE ANSWER *"YES"* OR *"NO"*

1. Do you have a pacemaker? _____
2. Have you had recent X-Rays? _____ **Date** _____
3. Do you have metallic implants, plates, artificial joints, etc.? _____ **(explain)**
4. Are you pregnant? _____ 5. Other illnesses _____