

**Office Use**

F/C :  INS  MC  SP  DD  DDS  WC  AA  PI PMANPVL # \_\_\_\_\_

Included :  Insurance Card Copy  Employer Claim Form  Referral / Script  Massage

**PATIENT INFORMATION**

Thank you for choosing Physical Medicine Associates - Naperville. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information :

Today's Date : \_\_\_\_\_ Patient's Soc. Sec. # : \_\_\_\_\_

First Name : \_\_\_\_\_ M.I. : \_\_\_\_\_ Last Name : \_\_\_\_\_

Mailing Address : \_\_\_\_\_

Zip Code : \_\_\_\_\_ City : \_\_\_\_\_ State : \_\_\_\_\_

Home # : ( \_\_\_\_\_ ) \_\_\_\_\_ Work : ( \_\_\_\_\_ ) \_\_\_\_\_ Cell : ( \_\_\_\_\_ ) \_\_\_\_\_

Date of Birth : \_\_\_\_\_  Male  Female

Employer : \_\_\_\_\_ Email : \_\_\_\_\_

Referred By :  Self  Friend  Insurance Carrier  Primary Physician  Other \_\_\_\_\_

**INSURANCE PATIENTS**

*Please complete the following section and present your Insurance Cards.*

PRIMARY INSURANCE		SECONDARY INSURANCE	
Relation to Insured:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
<b>Complete the following Insured information if RELATION is other than SELF.</b>			
Insured's Name:			
Insured's Birthdate:			
Insured's Insurance ID:			
Male or Female:			
Employer:			

**ACCIDENT PATIENTS**

CLAIM FILING INFORMATION	
WORK COMP OR MEDPAY INFORMATION	ATTORNEY INFORMATION
Date of Injury:	<input type="checkbox"/> Attorney Only - <u>no</u> WC or Medpay Info
Insurance Carrier Name:	Name :
Carrier Address:	Address :
City, State, Zip:	City, State, Zip :
Adjuster's Name:	Contact :
Adjuster's Phone : ( _____ ) _____	Phone : ( _____ ) _____
Claim Number:	File No. :

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges; which may also include legal, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services. I understand that for any balance remaining on my account past 30 days, pursuant to Physical Medicine Associate's discretion, my account may be turned over to collections or there will be a monthly late fee assessed of \$15 for up to 3 months, and after that time my account may be turned over to collections

Patient Signature : \_\_\_\_\_ Date : \_\_\_\_\_

Name: \_\_\_\_\_

**Personal and Family Health Information**

Please indicate if you have any of the following conditions:

	Currently		In the Past		Family	
	Y	N	Y	N	Y	N
Heart Disease						
High Blood Pressure						
High Cholesterol or Triglycerides						
Heart Attack						
Pacemaker						
Lung Disease						
Asthma						
Allergies (environmental or industrial)						
Strokes						
Paralysis						
Peripheral Arterial Disease						
Peripheral Neuropathy						
Kidney Disease						
Cancer (type _____)						
Arthritis						
Osteoporosis						
Hepatitis- circle type A B C D						
Cirrhosis of the Liver						
Gall Bladder Trouble						
Hemochromatosis						
Pancreatitis						
Stomach Ulcers						
Hyperthyroidism						
Hypothyroidism						
Diabetes						
Chronic Back, Neck, or Spine Problems						
Multiple Sclerosis						
Parkinson's Disease						
Epilepsy						
Glaucoma						
HIV/AIDS						
Bleeding Disorder						
Leukemia						
Lymphoma						
Anemia						
Tuberculosis						
Pelvic Inflammatory Disease						
Depression/Anxiety						
History of Breast Lumps						
Other _____						
Other _____						

Name: \_\_\_\_\_

**Prescription Medications** (please use additional sheet if necessary)

Name	Dose (mgs.)	# of Times/Day	Purpose of Medication

**Prescription Medication Allergies**

Drug	Type of Reaction

If you do not know of any medications you are allergic to, please check this box

**Supplements (Vitamins/Minerals/Herbs/Nutraceuticals, etc.)**

Name	Dose (mgs.)	# of Times/Day	Purpose of Medication

**Approximate Date of Last:**

Physical Exam:	Chest X-Ray:
Blood Test:	Colonoscopy:
Urine Test:	EKG:
HIV/AIDS Test:	Flu Shot:
Pap Smear:	Pneumonia Shot:
Mammogram:	Tetanus Shot:
Osteoporosis Scan:	MRI, CT-Scan, or Bone Scan:

**Surgeries**

Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

**Serious injuries** (e.g. head injuries, falls, broken bones)

Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

Name: \_\_\_\_\_

**Today's Visit**

What is the reason for your visit today?

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What treatment have you already received for this condition, if any?

Medications    Surgery    Physical Therapy    Chiropractic Services    Acupuncture    Massage  
Other \_\_\_\_\_    None

What other doctors, facilities, etc., if any, have you seen for this condition? Please list names and practice locations to the best of your ability.

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**If your condition involves pain, please complete the following section.**

1. Is your condition getting worse?    Yes    No    Unknown
2. Have you had anything like this before?    Yes    No
3. How often do you have this pain? \_\_\_\_\_
4. Please circle the best description of your pain.  
Constant  
On and off, lasting    \_\_\_ minutes    \_\_\_ hours    \_\_\_ days    \_\_\_ weeks    at a time.

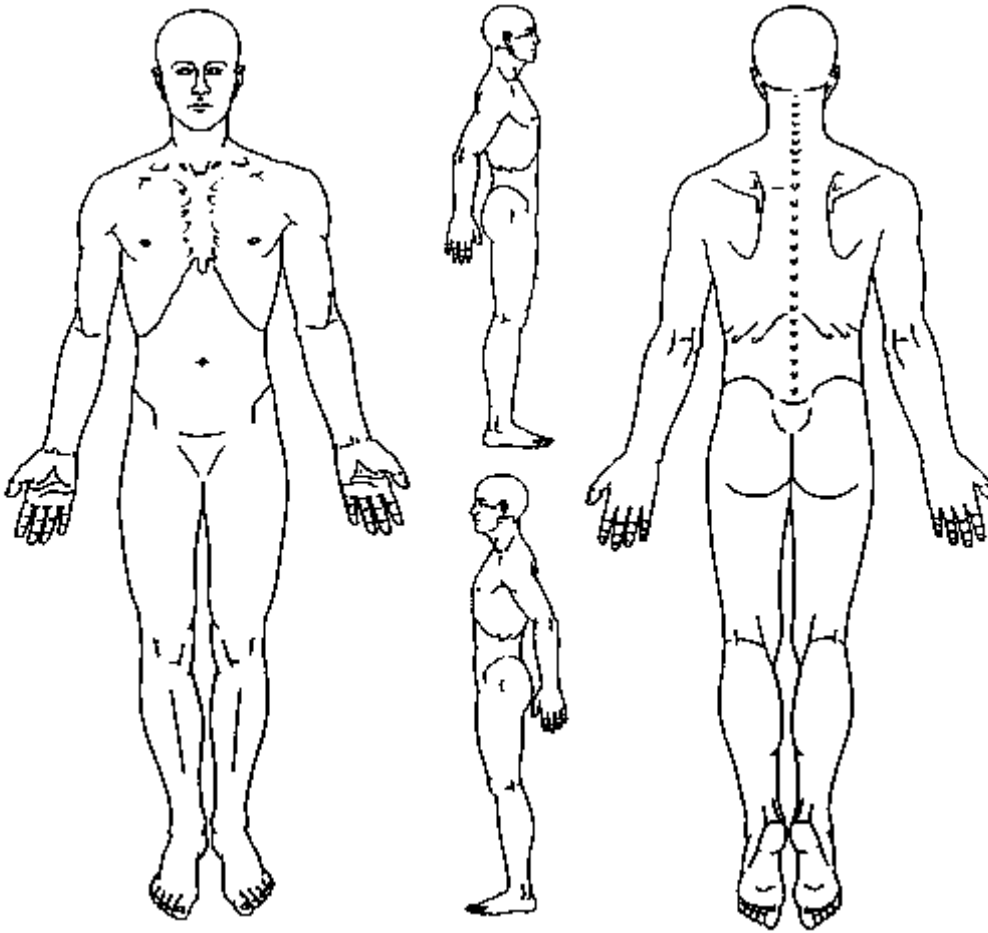
**For questions 5 -7, circle all that apply.**

5. Describe how it feels: Numb    Aching    Pins and Needles  
Throbbing    Cramping    Stiffness    Burning    Stabbing    Dull    Sharp
6. Does it interfere with: Work    Sleep    Recreation    Daily Routine
7. Activities that are painful to perform: Sitting    Standing    Walking    Bending    Lying Down
8. Please rate your pain on the scale below.    0= No Pain and 10= Severe Pain

1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Pain currently	Pain at its worst	Pain typically

Name: \_\_\_\_\_

9. Please mark the area(s) of injury or discomfort as shown in the example below.  
N= Numbness    P= Pins and needles    A= Aching    B= Burning    S= Stabbing



**Lifestyle Questions**

How many days/week do you do formal exercise (weight lifting, running, yoga, etc.)? \_\_\_\_\_  
What is the main activity you do in regards to the above exercise? \_\_\_\_\_  
How many times/week do you engage in aerobic sports like basketball, tennis, biking, etc? \_\_\_\_\_  
Does your occupation require mostly:    Sitting    Standing    Light Labor    Heavy Labor  
In your own opinion, how is your diet?    Terrible    Poor    Average    Excellent  
How many 8 ounce glasses of plain water do you drink/day? \_\_\_\_\_  
How many caffeinated beverages (coffee, tea, and cola) do you drink/day? \_\_\_\_\_  
Do you consider yourself to be under a great deal of stress?    Yes    No  
Do you smoke cigarettes?    Yes    No  
Do you smoke cigars, tobacco, a pipe?    Yes    No    If so, how often? \_\_\_\_  
How many alcoholic beverages do you drink/week? \_\_\_\_\_  
Do you use any recreational drugs?    Yes    No  
Do you practice safe sex, if at all?    Yes    No  
Are you currently pregnant?    Yes    No    Due Date: \_\_\_\_\_

**Please return this packet to the receptionist along with a copy of your insurance card(s) and driver's license so that we may make a copy of them.  
Your doctor will be with you shortly.**