Maumee Physical Therapy & Aquatics Center

Sports Medicine • Aquatic Therapy • Orthopedics • Industrial Rehabilitation

Patient Information (please print)

Patient Name: ________________________________ Home Phone:(_______)______________________

Address:____
City State Zip

Date of Birth:________________________________ Sex (please check) Male ______ Female _____

Social Security Number ______________ Marital Status: Single ___ Married___ Divorced ___ Widowed ___

Email Address (optional)____

Patient Employer:____________________________________ Work Phone:(________)________________

Employer Address:____
City State Zip

Responsible Party Information (Parent/ Guardian- if patient is a minor)

Name:____ Home Phone: (_______)_________________

Address:____
City State Zip

Date of Birth:________________________________ Sex (please check) Male_______ Female _____

Social Security Number:______________________ Employer:____________________________________

Employer Address: _____________________________________ Work Phone:(________)______________

Health Insurance Information – Primary

Insured Name _______________________ Insured Date of Birth:____________ Sex: Male ___ Female ___

Insured ID Number_____________________ Group Number: _____________________________________

Patient's Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Insurance Company Name:____

Insurance Company Address:____
City State Zip

Health Insurance Information-Secondary

Insured Name ______________________ Insured Date of Birth:___________ Sex: Male ___ Female ___

Insured ID Number:______________________________ Group Number: ____________________________

Patient's Relationship to Insured: Self____ Spouse ____ Child ____ Other ____

Insurance Company Name: ____

Insurance Company Address:____
City State Zip

Physician

Referring Physician ________________________ Primary Care Physician ___________________________

Date of Next appointment with Referring Physician:____

Symptom/Treatment Information (Mandatory)

Diagnosis or Area of Symptoms:__________________________ Date of Injury or Onset:_______________

Have you received any prior chiropractic, physical, occupational or speech therapy for this condition? Yes__ No __

Medicare Patients Only

Have you had medical care in your home in the past 60 days ? Yes ____ No ____
If yes, please give date(month/year):____

Agency that provided the care:____

Accident

Are your symptoms related to an accident? Yes ___ No ___ Auto Accident? Yes ___ No ___

Accident Date: __________________________ State in which accident occurred:________

Employment –Related Injury (Worker's Compensation)

Are your symptoms employment related? Yes __ No __ BWC Claim #_____________Injury Date:________

Employer at time of injury:____

Employer Address:____
City State Zip

Emergency Contact

Emergency Contact:________________________________ Emergency Phone:_______________________

Emergency Address:____
City State Zip

Relationship to Patient: ____

How did you select our services:

Doctor's Referral_________ Friend's Recommendation___________ Ad in Yellow Pages ___________

Had Previous Therapy Here____________ Google Search_____________ Other__________________

Authorization for Treatment/Insurance Authorization /Assignment and Guarantee of Account

I authorize treatment as deemed necessary by the therapist. I assign my insurance benefits directly to Comprehensive Rehabilitation Group, Maumee Physical Therapy , or The Spine Care & Rehabilitation Center, whichever is applicable.
I understand that unless my signature is affixed, claims cannot be submitted for me and I will be responsible for the charges at the time of service.
I hereby consent to the release of my medical records to the following persons: facility personnel, attending physicians and consultant; any person, firm, government entity, third party payor or managed care organization responsible for all and any part of reimbursement of the patient's charges.
The responsibility for insurance benefit verification rest with the patient. We will submit the claims to the health insurance companies which have been indicated, however cannot be held responsible for knowing your benefits. We cannot know what, if any, referral or authorization requirements your company may have designed for your policy. All patients are financially responsible for charges incurred regardless of health insurance coverage and it is to the patient's benefit to become familiar with the limits of his/her insurance benefits as early as possible to facilitate informed treatment decisions.

Patient Signature:____ Date:________________________
(Parent/Guardian if patient is a minor)