ADVANCED REHABILITATION MEDICAL SERVICES, INC.

4265 Laura Street	***223 Martin Luther King Blvd.***
Charlotte Harbor, FL 33980	***Punta Gorda, FL 33950***
941.764.7117	***941.833.4335***

Web Site: www.advancedrehabilitation.com

Please print legibly and complete all of the following information so we may register you properly and bill your insurance company appropriately. ***Thank you.***

Patient's Name: Last First Initial Jr/Sr/I,II,III, etc.

Reason for today's visit/chief complaint:				
Height:	Weight	Allergies:		
Guarantor/Responsible Party Name: Last			First	relationship
Guarantor/Responsible Party Name if Minor:Last			First	relationship
Patient's **Social Security Number**			Driver's License (Provide to copy for ID)	
Patient's **Permanent Physical Address**:				
City:	State:		Zip:	Phone:
Patient's **Local Address**:				
City:	State:		Zip:	Phone:
Sex: M F	**Date of Birth**:Month	Day	Year	Age:
Marital Status: M S D W		Other		
Requesting Physician Name:			Address:	
Other Referral Source: Self	Phone Book		Web Site	Family

Employment Status: Employed	Self Employed	Unemployed	Retired	Other
Employer:		Occupation:		
Employer Address:				
Work Phone:		Supervisor/Contact Person:		

Is this Worker's Comp? Yes No	If yes, please describe accurately and honestly in this section			
Stop! You will need authorization for this visit and any treatments rendered in this office prior to the first visit.				
Date of injury or accident at work:		Claim#		
Nature of Accident:	At work:	Personal:	Auto:	Other:
Briefly describe the accident:				
Have you been involved in any prior accidents?				
Do you have symptoms or injuries as a result of a prior accident?				
Name of insurance company handling Worker's Comp:				
Billing Address:	State		Zip	
Phone	Case Manager/Contact Person:			
Have you retained an attorney? Yes No	Name:		Phone#	

Is this an Auto Accident? Yes No	If yes, please describe accurately and honestly in this section		
Date of the Accident/Loss:	Claim#:		
Nature of accident:	Briefly describe the accident:		
Have you been involved in any prior accidents?			
Do you have symptoms or injuries as a result of a prior accident?			
Name of insurance company handling auto accident:			
Billing Address:	State	Zip	
Phone: Contact Person:			
Have you retained an attorney? Yes No	Name:	Phone#	

Other type of accident case? Yes No If yes, describe
Is there an attorney involved? Yes No Name of attorney/law firm: Phone
Where should the bills be sent? Who is responsible for paying the bills?

Primary Insurance: Medicare: Yes No Medicare #
~ If this is a Medicare HMO, you will need authorization from your primary care physician prior to first visit

Primary Insurance other than Medicare? Yes No Insurance Name:			
Do you need authorization for this visit? Yes No If yes, you will need authorization prior to first visit.			
Subscriber's Name:	Contract/ID#:	Group#	Provide card to copy
Secondary Insurance			
Do you need authorization for this visit? Yes No If yes, you will need authorization prior to first visit.			
Subscriber's Name:	Contract/ID#:	Group#	Provide card to copy
Other Insurance			
Do you need authorization for this visit? Yes No If yes, you will need authorization prior to first visit.			
Subscriber's Name:	Contract/ID#:	Group#	Provide card to copy

Emergency Contact:	Relationship:
Address:	Phone#:
Next of Kin:	Relationship:
Address:	Phone#:

I have completed the above information honestly and accurately to the best of my knowledge. I understand that I am responsible for payments and/or co-payments at time of services. I have received a copy of the Notice of Privacy Practices.

Signature: First Initial Last Date

Please complete the following:

HEALTH HISTORY:

List Present Medical History/diagnosis/medical problems:
List prior treatments related to your problems:
List Past Medical History/diagnosis/medical problems:
List Past Surgeries and Dates:
List any other pertinent information you need the physician to know:

List all of the physicians who are currently treating you:

**** See Medication Profile for Medications, Allergies, Reactions, etc.**

Have you ever had any of the following? Pleaes circle and note how long.

Diabetes
High Blood Pressure
Cardiovascular Problems
Palpitations
Chest Pain
Fatigue
Shortness of Breath
Gastrointestinal problems
Ulcers
Constipation / Diarrhea
Stomach upset
Fever
Chills
Headache
Back Pain
Fainting
Loss of smell
Loss of taste
Face flushed

Neck Pain
Neck Stiffness
Numbness in Fingers
Pins & Needles in Arms
Pins & Needles in Legs
Numbness in Toes
Numbness in Legs
Loss of Balance
Loss of Memory
Lights bother eyes
Head seems heavy
Nervousness
Sleeping Problems
Tension
Ears ringing
Feet cold
Hands cold
Buzzing in ears
Irritability

Other symptoms, explain:								
Do you have pain in Muscle/Joint?							Bone Location:	
Arms	Back	Hips	Legs	Feet	Neck	Hands	Shoulders	Other
Pain Assessment:								
Dull ache	sharp		stabbing		burning		radiate.	where

Do you notice any activity restrictions as a result of these problems:

If any type of accident, please complete the following:

Describe how you felt at time of accident:
During the accident:
Immediately after the accident:
Later that day:
The next day:
What are your current symptoms and complaints?
Were you transported to a hospital?
Were you treated by another physician since the accident? Please explain:
What type of treatment did you receive?