Mariposa Physical Therapy
Patient Information Sheet

Home Phone:__________________ Work Phone:________________________
Date of Injury_________________ Date of Surgery:_____________________

Patient Name:____Male:_____Female:_____
(Last) (First) (Middle)

Physical Address:____
(Street) (City) (State) (Zip)

Mailing Address:____
(If different than above)

Social Security #:_____________________________Date of Birth:______________________
Marital Status: S_____M_____SEP_____DIV_____WID_____
Parent/Spouse:_____________________________Parent/Spouse SSN____________________
(If required by Insurance to obtain benefits)

Emergency contact:______________________________Phone:________________________
Referring Physician:______________________Primary Physician______________________

Employer:_______________________________________Phone:________________________
Address:____
(Street) (City) (State) (Zip)

Is this a Worker's Compensation Claim? Yes_____ No_____
Is this an Automobile Accident Claim? Yes_____ No_____
Is this a Personal Injury Claim? Yes_____ No_____
Have you retained an attorney to represent you ina nay of the above claims? Yes_____ No_____
If "yes" list attorney Name and Phone:
Name:____Phone:________________________

ASSIGNMENT AND RELEASE

I hereby authorize treatment by Mariposa Physical Therapy. I hereby authorize my insurance benefits to be paid directly to Mariposa Physical Therapy and I am financially responsible for services rendered.

Signature:____Date:_________________

*******Financial Policy*******
I have received a copy of Mariposa Physical Therapy's Financial Policy relating to private insured and cash patients. Signature:____________________________________Date:_________________

*******Workers' Compensation Info*******
I have received a copy of Mariposa Physical Therapy's Workers' Compensation Information sheet. Signature:_________________________________Date:_______________

Medical Information

Please complete all requested information:

	YES	NO
High Blood Pressure	____	____
Heart Problems	____	____
Pacemaker	____	____
Circulation Problems	____	____
Seizures	____	____
Dizziness	____	____
Significant Weight (Gain or Loss)	____	____
Tuberculosis	____	____

	YES	NO
Breathing Problems	____	____
Bowel/Bladder Dysfunction	____	____
Fractures	____	____
Stroke	____	____
Arthritis	____	____
Claustrophobia	____	____
Hepatitis	____	____
Hearing Aid	____	____
Diabetes	____	____

Please list all other illnesses or conditions:____

Have you ever had any type of Cancer: YES____NO____ If yes please list:

Please list any medications you are now taking:______________________________________

Are you allergic to any medications? YES____NO____ If yes please list:

Do you have any metal in your body (other than your teeth)? YES____NO____If yes please list:

Have you had surgery within the last 5 years? YES____NO____ If yes please list dates, types and outcomes:

Do you have trouble with your vision? YES____NO____

Have you ever had physical therapy treatments before? YES____NO____ If yes please list:

FEMALES ONLY:

Are you now pregnant? YES____NO____ Date of last menstrual cycle:________________