Dunwoody: 4505 Ashford Dunwoody Rd Ste 13
Atlanta, GA 30346
Roswell: 1305 Hembree Rd Ste 101
Roswell, GA 30076
P: (770) 393-0111 F: (770) 393-0109

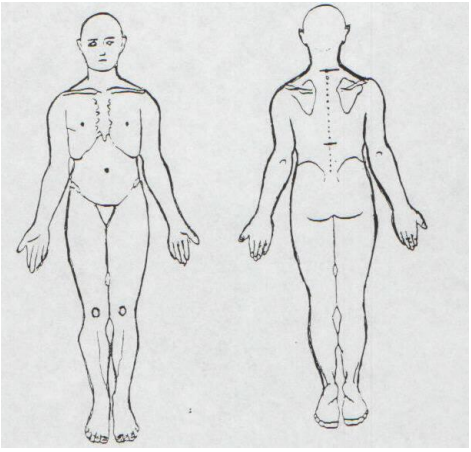
*** Welcome and thank you for choosing us for your physical therapy and Pilates needs. All patients or responsible parties must complete this form and provide picture identification and insurance card(s) prior to being seen.***

Name _____ Birth date_____
Home Address_____ City, State, Zip_____
Ph Number _____home/ cell/ work Email_____
Social Security # _____-_____-_____ Marital status: Single Spouse Divorced Widowed
Occupation_____ Employer _____
Emergency Contact _____Relation_____Ph Number: _____
How did you hear about us? _____

Past Medical History	Yes	No
Anemia		
Anxiety		
Arthritis		
Asthma		
Cancer		
Cardiac Conditions		
Cardiac Pacemaker		
Circulation Problems		
Currently pregnant		
Depression		
Diabetes		
Dizzy spells/Vertigo		
Emphysema/ Bronchitis		
Fractures/ Broken Bones		

Past Medical History	Yes	No
Gallbladder Problems		
Hepatitis		
HIV		
High Blood Pressure		
Multiple Sclerosis		
Osteoporosis/Osteopenia		
Parkinson's Disease		
Rheumatoid Arthritis		
Seizures		
Speech Problems		
Stroke		
Thyroid Disease		
Tuberculosis		
Vision Problems		

Please list prior surgeries and approximate dates:_____
_____
Do you have any contact allergies, such as latex, lotions, etc? _____
Any health conditions or previous injuries not listed:_____
Please list current medications OR circle→ I've provided a copy of my medication list
_____
Indicate the site(s) of your pain or problem(s) on the diagram below:



* Does your pain/problem interfere with sleep? _____
* Does your pain/problem interfere with your everyday activities?_____
* On a scale of 0 to 10, where 0 is no pain and 10 is "emergency room" pain, what is your pain at its worst_____ and best____?
* What do you want to achieve with physical therapy/Pilates?
_____
_____

FINANCIAL POLICY

We appreciate your choosing us to participate in your health care. We will bill your insurance carrier in a timely fashion provided that current and accurate information is supplied at the time of service; however, the patient is ultimately responsible for all fees incurred in our office. Any services not paid by your insurance coverage will become your responsibility to pay in full upon receipt of notification from our office. We do not guarantee information during our insurance coverage verification and we encourage you to research your out-of-pocket costs with your insurance company. All copayments and deductibles are due at the time of service. A fee of $25 may be added to your account for any check returned by your bank. **Cancellation Policy: Less than 24-hour notice will result in a $50 cancellation fee.**

I acknowledge and agree with the terms of this financial policy and authorize payment of benefits according to the terms of my insurance policy to OnCore PT, Inc for services rendered. I authorize OnCore PT, Inc to release any medical information necessary to process insurance claims.

PATIENT SIGNATURE_____**DATE**_____

CONSENT FOR TREATMENT

By signing below, I consent to receive physical therapy treatment from a licensed physical therapist or physical therapy assistant employed by OnCore PT, Inc.

PATIENT SIGNATURE_____**DATE**_____

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I have had the opportunity to review the privacy practices of OnCore PT, Inc. and authorize OnCore PT, Inc. to share my personal health information with my referring physician and any other individual(s) I list below:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

I authorize any agent of OnCore PT, Inc. to leave a voice message on my phone if I do not answer.

PATIENT SIGNATURE_____**DATE**_____