fitness & rehab

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Physical Therapy

Tel: (732) 244-5533 • Fax: (732) 244-6766 • www.fitnessandrehab.com

Joseph V. Napolitano, PT, 40QA00373400

NAME _____
PRINT LAST FIRST

ADDRESS _____

CITY_____ STATE_____ ZIP_____ EMAIL _____

S.S.#_____ AGE_____ DATE OF BIRTH_____ MARITAL STATUS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PATIENT'S EMPLOYER _____
(IF MINOR, THEN PARENT)

ADDRESS _____

OCCUPATION_____ ARE YOU WORKING NOW? ☐ YES ☐ NO (CIRCLE ONE) FULL TIME PART TIME

SPOUSE'S NAME _____

INSURANCE INFORMATION **PRIMARY** **SECONDARY**

INS. CO. NAME _____ INS. CO. NAME _____

INS. CO. ADDRESS _____ INS. CO. ADDRESS _____

_____ _____

INS. CO. TELEPHONE_____ INS. CO. TELEPHONE_____

NAME OF POLICY HOLDER _____ NAME OF POLICY HOLDER _____

POLICY #_____GROUP # _____ POLICY #_____GROUP # _____

CLAIM #_____ CLAIM #_____

IS THIS A COMPENSATION CASE ? ☐ YES ☐ NO DATE OF ACCIDENT _____/_____/_____

IS THIS A LIABILITY CASE? ☐ YES ☐ NO ☐ MVA ☐ NEGLIGENCE DATE OF ACCIDENT_____/_____/_____

IN YOUR OWN WORDS PLEASE EXPLAIN HOW INJURY OCCURRED: _____

_____

_____

_____

IF APPLICABLE ATTORNEY'S NAME _____

ATTORNEY'S ADDRESS _____

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT.
I authorize treatment of the person named above & agree to pay all fees & charges for such treatment. I agree to pay all charges to me shown by statements promptly upon presentation therof unless credit arrangements are agreed upon in wrinting. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims, thereon & all proceeds of insurance are assigned to this office where applicable but without their assuming responsibility for the collection thereof. I also authorize Fitness In Therapy to release such information as required by the above insurance carrier.

PATIENT'S SIGNATURE_____ DATE_____
(IF MINOR, THEN PARENT)

1. ARE YOU CURRENTLY TAKING ANY MEDICATION? PLEASE LIST MEDICATION AND REASON FOR USE.

2. HAVE YOU EVER HAD:

	YES	NO
HEART ATTACK		
ANGINA PECTORALIS		
EKG ABNORMALITIES		
EMPHYSEMA		
CHRONIC BRONCHITIS		
LOW BLOOD PRESSURE		
HIGH BLOOD PRESSURE		

	YES	NO
KIDNEY DISEASE		
EPILEPSY		
ANEMIA		
ASTHMA		
NECK OR BACK DISORD.		
FRACTURES		
WHERE:		

HAVE YOU EVER HAD:

	YES	NO
PULMONARY SURGERY		
DIABETES		
SCARLET FEVER		
RHEUMATIC FEVER		
BONE OR JOINT DISEASE		

	YES	NO
STROKE		
THYROID TROUBLE		
DISEASE OF ARTERIES		
LOW BLOOD SUGAR		
GLAUCOMA		

4. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS? YES ____ NO ____
IF YES, PLEASE GIVE DETAILS:

5. PLEASE LIST ANY OTHER PHYSICAL DISORDERS YOU HAVE OR HAD WHICH SHOULD BE CONSIDERED REGARDING YOUR PHYSICAL THERAPY AND EXERCISE PROGRAM (I.E. PREGNANT, ETC.)

FAMILY PHYSICIAN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WOULD YOU LIKE YOUR FAMILY PHYSICIAN TO RECEIVE A COPY OF YOUR PHYSICAL THERAPY REPORT ____ YES ____ NO

_____

PATIENT'S INITIALS (IF MINOR, THEN PARENT)