Patient Information Sheet

Name:_______________________________________SS#:_________________________DOB:______________

Address:_____________________________________ City:________________________ NC ZIP:____________

Phone # _____________________ Emergency Contact/Phone: ______________________________________

Primary Physician:____Date of Last Physical:__________

Height: _______________________ Weight: ______________________ BMI: _________________________

Chief Complaint:____ Onset Date:___________________

Previous Surgeries: ____

Is this related to an automobile or work accident? Yes _____ No ____ Date of Accident: ______________

Primary Insurance Policy Owner____ DOB:____________

Relation to Patient: ____ SSN: ________________________

Check if you have been diagnosed with any of the following:

◯High Blood Pressure ◯Heart Disease ◯Pacemaker ◯Blood Clot ◯Diabetes

◯Angina/Chest pain ◯Weight Change ◯Seizure ◯Incontinence ◯Cancer

◯Asthma/Allergies ◯Dizziness ◯Headache ◯Nausea ◯Confusion

◯Numbness/Tingling ◯Arthritis ◯Depression ◯Osteoporosis ◯Stroke

◯Respiratory Issues ◯Kidney Disease ◯Short of Breath ◯Sexually Transmitted Disease

At Kinetic Institute Physical Therapy we pride ourselves with providing the highest quality of care to each of our patients. We have the following expectations of you to ensure that our work together optimizes your goals and ensures an excellent experience with our office.

- Please silence cell phones so as not to disturb others.
- Arrive 5 minutes prior to your appointment time so we can keep on schedule and maximize our time with you.
- **We have a strict cancellation policy.** Please give 24 hours' notice if you are unable to make your scheduled appointment.

Consent For Treatment

I hereby agree to give my consent to medical treatment in treating my current physical condition. I authorize the release of any medical information needed to process my claim. Filing my insurance is done as a courtesy to me and does not guarantee payment. I understand that I am responsible for any charges that are not covered by my insurance carrier and I am responsible for understanding the details of my insurance coverage. I understand that I am to inform this office of any changes to the insurance I gave, deductibles or coverage limitations. I authorize payment directly to Kinetic Institute regardless of participation in or out of network. Should I default on my financial responsibility, I understand that I will be presented to collections and responsible for any charges that are incurred. I have read and understand the guidelines listed above and the cancellation/no-show policy. I also acknowledge that I have seen the "Notice of Privacy Practices."

Patient/Guardian Signature: ____Date:___________________