301 Lavinder Street Martinsville, VA 24112
Phone: 276 -632-5281 Fax: 2766326884

Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security:	Gender: Male Female
Address:	City, State, Zip:	
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Referring Physician:	Primary Care Physician:	
(Circle) Single Married Divorced Widowed	**(Circle)** Employed Retired Disabled Student (full/part time)	
Employer:	Occupation:	Phone:
Emergency Contact:	**Phone Number:**	**Relationship:**

Responsible Party Information

Relationship to patient:		
Last Name:	First Name:	Middle Initial:
Address (if different)	Date of Birth:	
City, State, Zip:	Social Security:	
If minor, obtain parent/guardian signature on "Treatment of Minors" authorization form	Phone Number:	

Insurance Information

Primary Insurance Company:	Subscriber Date of Birth:
Subscriber Name:	Subscriber Social Security:
Relationship to Subscriber:	

Visit Information

Injury Date:	Work Injury: Yes No	Sports Injury: Yes No
Surgery Date:	Surgery Type:	

Motor Vehicle Accident? YES NO **Motor Vehicle Accident Date:________________**

Which state did your work injury or car accident happen in? ________

Are you at fault for car accident : (Circle) Yes No

Is there a possibility of third party insurance company (e. MedPay) attorney making payments on your behalf?

(Circle) Yes No Attorneys Name:______________________________

If yes, patient must sign our "Agreement of Proceeds, Contractual Lien Authorization Agreement

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Are you currently receiving Home Health Services? (Circle) Yes No
If yes, please list name of home health agency and discharge date: (*should you not inform us of Home Health Services and insurance denies any charges you will be responsible*)
Have you recently received any other home health services? Yes No **If yes please list facility and type of therapy:**

Patient Health History

Do you have history of?	Y	N		Y	N		Y	N
Cancer			Diabetes			High Blood Pressure		
Heart Problems			Arthritis			Stroke/CVA/TIA		
Nausea/ Vomiting			Osteoporosis/ Osteopenia			Pacemaker		
Fractures			Bowel/Bladder Incontinence			Vascular Disease		
COPD			Metal Implants			Blood Clots		
Seizures			Numbness/Tingling			Are you pregnant?		

Please list any other conditions for which you have received medical treatment:____

Please list or provide attachment of all previous surgeries:____

How did you find out about Therapy Direct? ____

Have you been a patient before? (Circle) Yes No

Please List person(s) you prefer we share your information with below:

Name:______________________________ Phone: ____________________ Relationship____________

Name:______________________________ Phone:____________________ Relationship_____________

Name:_____________________________ _Phone:_____________________ Relationship____________

Patient Signature____________________________________ Date:______________________