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:	
Height:	Weight:	Email:
Home Phone:	Cell Phone:	Work Phone:
How would you like us to remind you of your appointments? **[TEXT]** **[CALL]** (Please circle)		
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 or subscriber:		
Primary Insurance Company:		
Subscriber Last Name:	Subscriber First Name:	Middle Initial:
Address (if different)		**Subscriber Date of Birth:**
City, State, Zip:		Subscriber Social Security:
If minor, obtain parent/guardian signature on "Treatment of Minors" authorization form		Phone Number:

HOME HEALTH SERVICES

Are you currently receiving any Home Health Services? Such as Nurse, Nurse Aid, PT/ OT/ Speech services **(Circle) Yes No**
If you circled YES when was your discharge date: _____ **Home Health Agency Name:_____ Phone Number: _____**

FRONT & BACK

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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

- **Have you ever been in a motor vehicle accident? YES / NO**
- **If you answered yes, is the above vehicle accident been closed per the insurance company? YES/ NO**

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:_____

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

Name:_____ Phone: _____ Relationship_____

Name:_____ Phone:_____ Relationship_____

Patient Signature_____ Date:_____

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