Top Tier Sports Medicine

Patient Information Date:____________________

Last Name: ________________________________ First Name: ______________________________ MI. ___________

Address:____ SSN: ____________________

City: ________________________________ State: ___________ Zip Code: ______________________________

Telephone#:(____)_______________ Mobile Phone #:(____)_____________ Work Phone#: (____)________________

Sex: Male / Female Date of Birth:____/____ /____ Email Address: _____________________________________

Marital Status
M S D W
☐ ☐ ☐ ☐

Employment Status
☐ Employed Full-time ☐ Employed part-time ☐ Unemployed
☐ Student Full-time ☐ Student Part-time ☐ Retired

Emergency Contact: _______________________________Relationship: ______________ Phone: _________________

Family Physician: __________________________________ Phone Number: ___________________________________

Financial Information: (If the patient is a minor, please complete this information)

Name of Responsible Party: ____ Relationship: _________________________

Home Address: ____

City: _____________________________________ State: ______ Zip: __________ Phone: ________________________

How did you hear about us?

☐ Referred by my physician ☐ Past Patient ☐ Friend, if so who may we thank? _________________

☐ Destination Brevard ☐ Running Zone ☐ Google ☐ Saw the Sign

Insurance Information:

Primary Insurance: ____ Member ID#: ___________________________

Policy Holder Name: ________________________________ Relationship: _______________ DOB: ____/____/_______

Secondary Insurance: ____ Member ID#: __________________________

Policy Holder Name: _______________________________ Relationship: _______________ DOB: ____/____/_______

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify Top Tier Sports Medicine of any changes in my status or the above information. I hereby authorize any treatment(s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize Top Tier Sports Medicine and its staff to call my home and leave messages regarding appointments with my spouse and/or on the answering machine. Furthermore, I authorize the use of facsimile transmission, e-mail transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment, and healthcare operations.

Patient or Responsible Party Signature: ____ Date: ____/____/_______

Determination of Primary Payer

Injury Date or Date pain began: ____________________ If Injury - Where did Injury Occur?

□ **No Accident** □Home □Work □Auto Accident- What State? ________

□Other_________________________

Have you been treated by another: (**Please CIRCLE all that apply**) physical therapist, chiropractor, or Home Healthcare agency since January 1st of this year? No ______ Yes______If yes, then:

Have you been discharged from their facility? No_________ Yes _________ Date last seen _______________

Please fill out the following information for each that applies:

Physical Therapy Office _________________________________ Phone #:_______________________

Home Health Care Agency___________________________________Date you were discharged?____________________

Have you had X-rays/MRI? When?_________________________ Where?_________________________

Medical History

Allergies	Yes □	No □	Dizzy Spells	Yes □	No □	MRSA	Yes □	No □
Anemia	Yes □	No □	Emphysema/Bronchitis	Yes □	No □	Multiple Sclerosis	Yes □	No □
Anxiety	Yes □	No □	Fibromyalgia	Yes □	No □	Muscular Disease	Yes □	No □
Arthritis	Yes □	No □	Fractures	Yes □	No □	Osteoporosis	Yes □	No □
Asthma	Yes □	No □	Gallbladder Problems	Yes □	No □	Parkinson's	Yes □	No □
Autoimmune Disorder	Yes □	No □	Headaches	Yes □	No □	Rheumatoid Arthritis	Yes □	No □
Cancer	Yes □	No □	Hearing Impairment	Yes □	No □	Seizures	Yes □	No □
Cardiac Conditions	Yes □	No □	Hepatitis	Yes □	No □	Smoking	Yes □	No □
Cardiac Pacemaker	Yes □	No □	High Cholesterol	Yes □	No □	Speech Problems	Yes □	No □
Chemical Dependency	Yes □	No □	High/Low Blood Pressure	Yes □	No □	Strokes	Yes □	No □
Circulation Problems	Yes □	No □	HIV/AIDS	Yes □	No □	Thyroid Problems	Yes □	No □
Currently Pregnant	Yes □	No □	Incontinence	Yes □	No □	Tuberculosis	Yes □	No □
Depression	Yes □	No □	Kidney Problems	Yes □	No □	Vision Problems	Yes □	No □
Diabetes	Yes □	No □	Metal Implants	Yes □	No □	Height _________ Weight __________		

Surgical History

Body Region: ______________________________ **Surgery Type:** _____________________________ **Date:** ________________

Body Region: ______________________________ **Surgery Type:** _____________________________ **Date:** ________________

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Current Medications

□ I do not take any medications □ See attached list of medications

Drug: ____________________ **Dosage:** _______ **Frequency:** ________ **Route:** ________ **Reason Taking:** ___________________

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PATIENT SIGNATURE: ____ **DATE:** __________________________

THERAPIST SIGNATURE: ____