Address: Marital Status: Telephone: (H) If Minor, Parent / Guardian NSURANCE INFORMATION Primary Insurance: Member ID No: Subscriber's Name: Subscriber's Birth Date: Subscriber's SS No: N/A Subscriber's Employer:	SS# N (C) How		Secondary Member ID Subscriber	E-Mail (W) Insurai	State PA Addres		Zip			
Telephone: (H) If Minor, Parent / Guardian NSURANCE INFORMATION Primary Insurance: Member ID No: Subscriber's Name: Subscriber's Birth Date: Subscriber's SS No: N/A	(C)		Secondary Member ID Subscriber	(W) Insuran		s:				
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	Subscriber's Employer:			Subscriber's Employer:						
VORKER'S COMP OR AUTO CLAI WC or Auto Insurance:	IM INFO	ORMATIO	N (Also compl Claim No		rance Inj	formation)				
Claim Adjuster Name:			Claim Adjuster Phone No:							
WC or Auto Ins. Address:		Date of I	njury:							
DIRECT PAYMENT REQUEST AND I hereby authorize King Physical Therapy to are Financing Administration and its agents ereby assign payment of said benefits to inci- Il charges regardless of insurance status as w uthorization shall be valid until rescinded in s valid as the original. I have read the above	o release i s, or any o clude Med well as any writing o	nformation a other third-particare benefits y associated or or replaced by	equired during the carrier as new solution of the carrier as new solutions of the carrier of the	he course essary to g Physica on should ate. A ph	of my exa secure pa Il Therapy Il such acti	amination and syment of any . I understan on become no	d treatment to the H y benefits due to me ad that I am responsi ecessary. I agree th			
eneficiary Signature				Da	nte					

Date

Beneficiary Signature

PAST MEDICAL HISTORY FORM

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 Yes No Headaches Yes No Rheumatoid Arthritis Yes No Sisorder Yes No Hearing Impairment Yes No Seizures Yes No Gardiac Conditions Yes No Hepatitis Yes No Smoking Yes No Cardiac Pacemaker Yes No High/Low Blood Pressure Yes No Speech Problems Yes No Speech Problems Yes No Cardiac Pacemaker Yes No High Cholesterol Yes No Stroke Yes No Cardiation Yes No High Cholesterol Yes No Thyroid Disease Yes No Cardiation Yes No Incontinence Yes No Thyroid Disease Yes No Cardiac Yes No Kidney Problems Yes No Cardiac Yes No Metal Implants Yes No COVID-19 Yes No Coviders Yes No Coviders Yes No Metal Implants Yes No COVID-19 Yes No Coviders	NAME					MI	DOB:	AGE		
work related injury	Are you presently v	working? Yes	No Dat	rate of next physician's visit: Date of injury/o				::		
motor vehicle accident recurrence of previous injury injury related to lifting injury related to falling athletic/recreational injury cause unknown other: Oo you have, or have you had any of the following? Idergies	Check which apply	to your sympto	ms:							
motor vehicle accident recurrence of previous injury injury related to lifting injury related to falling athletic/recreational injury cause unknown other: Oo you have, or have you had any of the following? Idergies	□ work relate	ed injury			Have you	ever had	these symptoms before	re?		
recurrence of previous injury		- ,								
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Injury related to falling			ii y		Have you h	nad a re	lated surgery?			
athletic/recreational injury cause unknown other:		_								
cause unknown other:		_			163	_ 140	-			
Or other:			1							
Or you have, or have you had any of the following? Allergies	cause unkr	nown								
Allergies Yes No Dizzy Spells Yes No MRSA Yes No Annews Yes No Emphysema/Bronchitis Yes No Multiple Sclerosis Yes No Kinemia Yes No Emphysema/Bronchitis Yes No Multiple Sclerosis Yes No Kinher Yes No Fractures Yes No Osteoporosis Yes No Kinher Yes No Fractures Yes No Osteoporosis Yes No Kinher Yes No Gallbladder Problems Yes No Parkinson's Yes No Schma Yes No Headaches Yes No Parkinson's Yes No No Headaches Yes No Remandatiol Arthritis Yes No Cardiac Conditions Yes No Hearing Impairment Yes No Seizures Yes No Sardiac Pacemaker Yes No High/Low Blood Pressure Yes No Speech Problems Yes No Speech Problems Yes No Schma Yes No Speech Problems Yes No Schma Yes No Sc	□ other:		_							
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Cardiac Conditions Yes No Hepatitis Yes No Smoking Yes No Cardiac Pacemaker Yes No High/Low Blood Pressure Yes No Speech Problems Yes No Chemical Yes No High Cholesterol Yes No Stroke Yes No Chemical Yes No High Cholesterol Yes No Stroke Yes No Cardiac Pacemaker Yes No High Cholesterol Yes No Stroke Yes No Cardiac Pacemaker Yes No Hilly/AIDS Yes No Thyroid Disease Yes No Covidens Yes No Incontinence Yes No Tuberculosis Yes No Experiession Yes No Kidney Problems Yes No Vision Problems Yes No Diabetes Yes No Metal Implants Yes No COVID-19	Disorder	res No	пеацаспеѕ		Yes I	VO	Kneumatola Arthritis	res No		
Cardiac Pacemaker	Cancer	Yes No	Hearing Impair	ment	Yes I	No	Seizures	Yes No		
Circulation	Cardiac Conditions	Yes No	Hepatitis				Smoking	Yes No		
Dependency	Cardiac Pacemaker	Yes No	High/Low Blood Pressure		Yes I	No	Speech Problems	Yes No		
Circulation Yes No HIV/AIDS Yes No Thyroid Disease Yes No Problems Yes No Incontinence Yes No Tuberculosis Yes No Problems Yes No Ridney Problems Yes No Vision Problems Yes No Diabetes Yes No Metal Implants Yes No COVID-19 Yes No Gody Region: Surgery Type: Date: Date: Surgery Type: Date: Date: Date: Dosage: Frequency: Route: Reason Taking: Do you participate in any sports, exercise programs, or activities on a regular basis? Yes No Date Pate No Date: Date Signature Date Signature Date Signature Date Signature Date Signature of Guardian, if Minor Date	Chemical Dependency	Yes No	High Cholesterol		Yes I	No	Stroke	Yes No		
Problems — Yes — No HIV/AIDS — Yes — No Inyroid Disease — Yes — No Currently Pregnant — Yes — No Incontinence — Yes — No Tuberculosis — Yes — No Diabetes — Yes — No Kidney Problems — Yes — No Vision Problems — Yes — No Diabetes — Yes — No Metal Implants — Yes — No COVID-19 — Yes — No F"Yes" to any of the above, please explain and give approximate date/describe any other conditions: Gurgical History	-									
Currently PregnantYes No		Yes No	HIV/AIDS		Yes I	No	Thyroid Disease	Yes No		
DepressionYes No		Yes No	Incontinence		Yes I	Nο	Tuherculosis	Yes No		
DiabetesYesNo Metal ImplantsYesNo COVID-19YesNo f "Yes" to any of the above, please explain and give approximate date/describe any other conditions: Surgical History				ıs						
f "Yes" to any of the above, please explain and give approximate date/describe any other conditions: Surgical History	Diabetes		-							
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	Patient's Signature			Date	Signature of Gua	ardian i	f Minor	Date		
Therapist's Signature Date	and it is signature			2410	3.6			Juice		
Tierapist's Signature Date		ro						Data		
	merapist's Signatu	ie						Date		

Patient Confidentiality

NAME:					МІ	DOB:	
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	uct, plan and direct my tre olved in that treatment dir			ng the multiple h	nealth ca	re providers who ma	у
Obtair	n payment from third-party	y payors.					
Condu	uct normal health care ope	erations such as	s quality as	sessments.			
uses and disc Notice of Priv	ed, read and understand y closures of my health info vacy Practices from time of the Notice of Privacy P	ormation. I und to time and tha	erstand tha	t <i>King Physical</i>	Therapy	has the right to cha	ange its
Signature:				Date:			7
Ito myself and	my medical condition wit			Physical Thera	apy to dis	scuss information pe	- rtaining
Family Meml	oer:			Phone #:			7
Friend:				Phone #:			1
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Are minor pat If yes, do pare If no, which pa	minor, please indicate the ient's parents divorced? ents share joint custody? arent has sole custody of e minor patient's health ca	Yes No Yes No minor?	o 	n-custodial pare	nt? Ye	es No	
	o obtain the patient's signa ment, but was unable to c	ature in acknow		of this <i>Notice of</i>	······	 Practices	
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