TOWN & COUNTRY MEDICAL, INC.

Patient Name: _____ **Date:** _____

REFERRING PHYSICIAN**:** _____

Physician last seen on: _____ Next Appointment with Physician: _____

Place an "X" for marriage status that applies

( ) Married

( ) Single

( ) Widowed

PATIENT INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____

Email Address: _____

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

City State Zip Code

Social Security #: _____- _____- _____ Date of Birth: _____/_____/_____

Month Day Year

IS YOUR CONDITION DUE TO ONE OR MORE OF THE FOLLOWING?

Please indicate the date of incident if available.

( ) Injury _____ ( ) Auto Accident _____ ( ) Symptom _____

( ) Surgery _____ ( ) Illness _____ ( ) Other _____

TOWN & COUNTRY MEDICAL, INC. WILL BILL YOUR PRIMARY INSURANCE ONCE BENEFITS ARE VERIFIED. PATIENTS ARE RESPONSIBLE FOR PAYING CO-PAYMENTS WEEKLY.

MEDICARE SUPPLEMENTS SHOULD BE DISCUSSED WITH US REGARDING BILLING. WE **DO** ACCEPT MEDICARE ASSIGNMENT OF BENEFITS & COLLECT ONLY THE AMOUNT MEDICARE ALLOWS.

Please place an "X" to which insurance applies.

( ) Medicare ( ) Worker's Compensation ( ) Automobile
( ) Medicare Supplement(s) ( ) Employer Group Plan ( ) Personal ( ) Veteran

TOWN & COUNTRY MEDICAL, INC.

Patient Name: _____ Date: _____

For Worker's Compensation, please fill out the following:

Employer Name: _____ Work PH: _____

_____

Employer Address: _____ Contact: _____

_____

Please place an "X" to indicate your current working status:

( ) Not working ( ) Modified Duty ( ) Full Duty

Job description:

_____
_____
_____
_____

Job restrictions:

_____
_____
_____

In order to return to work full duty, I must be physically able to perform:

_____
_____
_____
_____

CONFIDENTIAL PATIENT HEALTH HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____

Please place an "X" in the space(s) provided if you have any of the following conditions:

( ) Pacemaker	( ) Hepatitis	( ) Kidney Disease
( ) Internal electrical stimulator	( ) Stroke	( ) Thyroid Disease
( ) Internal Pain Pump	( ) Swollen Ankles	( ) Ulcers
( ) Metal Implant/Joint replacement	( ) Sinusitis	( ) HIV
( ) Heart Disease	( ) Asthma	( ) Heart Murmur
( ) Diabetes	( ) Cancer	( ) Colitis
( ) Prolapsed Mitral Valve	( ) High Blood Pressure	( ) Epilepsy
( ) Glaucoma	( ) Lung Disease	( ) Artificial Prostheses
( ) Tuberculosis	( ) Rheumatic Fever	( ) Hearing Loss
( ) AIDS	( ) Osteo Arthritis	( ) Pregnant
( ) Liver Disease	( ) Rheumatoid Arthritis	( ) Pain
( ) Leukemia	( ) Mental/Psychiatric Disorder	

<u>Do you have any allergies to the following?</u>

( ) Latex ( ) Adhesives ( ) Lotions/Creams ( ) Other: _____

_____

_____

Have you fallen within the past 12 months? ( ) YES ( ) NO

If answered yes, did an injury occur? ( ) YES ( ) NO

Do you walk with an assistive device? ( ) YES ( ) NO

If answered yes, how often do you use your assistive device? ( ) At home only

( ) Community only

( ) All the time

( ) Other:_____

CONFIDENTIAL PATIENT HEALTH HISTORY

Name: _____ Date: _____

Reason for therapy appointment: _____

Date of onset: _____ **Description of onset:** _____

Please **Rate Pain Level** (0) is no pain, (10) is worst possible pain:

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Best Pain in last week	0	1	2	3	4	5	6	7	8	9	10
Worst Pain has been in last week	0	1	2	3	4	5	6	7	8	9	10

Have you had any physical therapy in the past year? ( ) YES ( ) NO

Other types of treatment for this condition (please circle):

Home Care Chiropractor Specialist Massage Other:_____

Have you had any diagnostic services for **this injury**? (please circle)

Xrays MRI CT Scan EMG/NCV

Is this condition **Work Related**? ( ) YES ( ) NO **Auto Accident**? ( ) YES ( ) NO

Please list any surgeries you have had:

_____
_____
_____

Please list current medications you are taking:

_____
_____
_____
_____

Who is your primary physician? _____

When was your last physical exam? _____

TOWN & COUNTRY MEDICAL, INC.

CONDITIONS OF ADMISSIONS

RELEASE OF INFORMATION: Town & Country Medical, Inc. may disclose all or any part of the patient's record to any person or corporation which may be liable under a contract to Town & Country Medical, Inc. or to the patient or to a family member or employer of the patient for all part of Town & Country Medical, Inc. charge, including but not limited to; hospital or medical service companies, insurance companies, workman's compensation carriers, welfare funds, or patient's employer.

TREATMENT CONSENT: The patient is under control of his physician, and the undersigned consents to any treatment or procedures rendered to the patient by Town & Country Medical, Inc. under the general and specific instruction of the physician. It is further understood that Town & Country Medical, Inc. is authorized to carry out all instructions of the patient's doctor that Town & Country Medical, Inc. is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Town & Country Medical, Inc. to provide me with treatment and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

I authorize the social security administration to disclose information regarding my Medicare coverage, including but not limited to verification of my Medicare number, effective dates and types of coverage to Town & Country Medical, Inc. I also request payment of government benefits to Town & Country Medical, Inc.

It is understood that this release remains effective for one (1) year unless otherwise revoked.

FINANCIAL RESPONSIBILITY: I hereby accept all responsibility for treatment and cost not covered or reimbursed by third-party payers. I hereby authorize payment of medical benefits directly to Town & Country Medical, Inc. for services described in statements rendered.

The undersigned certifies that he has read the foregoing and is the patient, or duly authorized by the patient as the patient general agent to execute the above and accept it's terms.

_____ _____

Patient's signature Witness

_____ _____

Signature of person authorized in Lieu of patient Date

_____ _____

Relationship to patient Reason why patient unable to sign

PRIVACY PRACTICES ACKNOWLEDGMENT

Town & Country Medical, Inc.

2801 SW College Rd. Unit 24
Ocala, FL 34474

7860 SW 103rd St Rd Bldg. 100
Ocala, FL 34476

Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____