



Corpore Sano, LLC
 Sports + Orthopedic Physical Therapy
 Bicycle Biometrics
 Sports Performance

Date _____ Therapist: _____ Appt. Date: _____

PATIENT INFORMATION

Last Name _____
 First Name _____ MI _____ Occupation _____
 Address _____ Employer _____
 City _____ Zip _____ Work Phone _____
 Home Phone _____ Emergency Contact _____
 Cell Phone _____ Phone _____ Relationship _____
 E-Mail Address _____
 Birth Date _____ Age _____ Sex: M _____ F _____ Referred By: _____
 Marital Status: S _____ M _____ D _____ W _____

INSURANCE INFORMATION

Are you subscriber (ins. through your employer) Y _____ N _____
 If no, name of Subscriber _____
 Relationship to the you _____
 ***Date of Birth of Subscriber _____
 (do not complete the following if insurance card provided)
 Insurance Company Name _____
 Policy Number _____
 Group Number _____
 Phone Number _____

Secondary Insurance Information

Name of Insured _____
 Relationship _____
 Date of Birth of Insured _____
 Insurance Company Name _____
 Policy Number _____
 Group Number _____
 Address _____
 Phone Number _____

Benefit Check For Clinic Use Only

Date Called: / / Custome Service Rep: _____ Effective Date: _____
 Copay: \$ _____ Deductable: \$ _____ Amount Met: \$ _____ Co-Insurance% _____
 Visit Limit # or \$ Amount: _____ # of Visits or Amount Used (if any): _____
 Pre-Auth Needed? Y / N _____ If yes, name of Primary Care Physician? _____
 Prescription/RX Needed? Y / N _____
 Comments: _____

Motor Vehicle Insurance if Auto Accident

(complete ONLY if you are here because of an auto accident)
 Name of Insured _____
 Relationship _____
 Date of Injury _____
 Auto Insurance Co Name _____
 Policy Number _____
 Claim Number _____
 Address _____
 Adjustor's Name _____
 Phone Number _____

WORKER'S COMPENSATION (L&I) INFORMATION

(complete ONLY if you are here because of a work accident)
 Employers Name (at time of injury) _____
 Date of Injury _____
 Claim Number _____
 Social Security # _____
 L&I Address _____
 Claims Manager _____
 Phone Number _____
 Fax Number: _____
 Claim Open: Yes/No _____ Visits Availale _____

MEDICAL HISTORY

Please mark on "Yes" or "No" to indicate if you have had any of the following:

	YES	NO
AIDS/HIV		
Allergies		
Anemia		
Angina		
Arthritis		
Artificial Joints		
Asthma		
Back Problems		
Bladder Problems		
Bleeding Disorders		
Blood Disorders		
Broken Bones/ Fractures		
Cancer		
Chemical Dependency		
Chest Pain		
Circulatory Problems		
Diabetes		
Ear Problems		
Epilepsy		
Eye Problems		
Fainting		
Fibromyalgia		
Foot or Leg Cramps		
Gout		
Headaches		
Heart Disease		
Hemophilia		
Hepatitis or Jaundice		
High Blood Pressure		

	YES	NO
Kidney Problems		
Liver Disease		
Low Blood Pressure		
Lung Problems (including Asthma)		
Neurological Problems		
Osteoporosis		
Phlebitis		
Psychiatric Care		
Radiation Treatment		
Rash		
Respiratory Disease		
Rheumatic Fever		
Shortness of Breath		
Sinus Problems		
Special Diet		
Stroke		
Swelling of Ankles and/or Feet		
Swollen Neck Glands		
Thyroid Problems		
Tired Feet		
Tuberculosis		
Ulcers/Stomach Problems		
Varicose Veins		
Venereal Disease		
Weight Loss, unexplained		

Other _____

For Men:

Have you even been diagnosed with prostate disease? Y____ N____

For Women:

Are you pregnant or think you might be pregnant? Y____ N____

Family Physician _____ Last visit date _____

SURGERIES

Year Reason

MEDICATIONS**ALLERGIES (medications, latex, etc.)**

Name of Drug / Supplement

Strength

Name

Reaction

Name of Drug / Supplement	Strength	Name	Reaction

HEALTH HABITS

Caffeine Do you drink caffeinated beverages? Y____ N____ How many per day? _____

Alcohol Do you drink alcohol? Y____ N____ How many per week? _____

Tobacco Do you currently use tobacco? Y____ N____ # packs per day _____
Have you previously used tobacco? Y____ N____Exercise Do you exercise or participate in any hobbies
or sports? Y____ N____ Please describe the exercise
How many days a week? _____
How many minutes on average a day? _____**TOP 3 REASONS FOR YOUR VISIT TO CORPORE SANO**

1. _____
2. _____
3. _____

CERTIFICATION

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.

SIGNED: _____

DATE: _____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that I will reimburse Corpore Sano, LLC a fee of **\$50.00** if I do not arrive for my previously scheduled treatment or cancel my treatment without at 24-hour notice. I also understand that Corpore Sano, LLC may contact my physician, insurance company and/or employer if I do not arrive for my scheduled treatment. Returned check fee: \$25.00 per occurrence.

SIGNED: _____

DATE: _____

AUTHORIZATION TO PAY CORPORE SANO, LLC

I hereby authorize my insurance benefits to be paid directly to Corpore Sano, LLC and I am financially responsible for non-covered services. I authorize Corpore Sano, LLC to release any information to process this claim.

SIGNED: _____

DATE: _____

*** CO-PAYMENTS ARE DUE AT TIME OF SERVICE ***