

McLean County Orthopedics

PATIENT INFORMATION

NAME: _____
LAST FIRST MI

BIRTHDATE: _____ AGE: _____ SS#: _____ - _____ - _____ GENDER: M F

ADDRESS: _____
STREET CITY STATE ZIP CODE

IF STUDENT - PERMANENT ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE NO.: _____ WORK PHONE NO.: _____

WILL THIS INJURY BE COVERED UNDER WORKER'S COMPENSATION? YES _____ NO _____

IS THIS INJURY COVERED BY? ILLINOIS PUBLIC AID MEDICARE BLUE CROSS / BLUE SHIELD

INSURANCE (NAME) _____ PRIVATE PAY _____

In order to control our costs of billing, we require that co-pays be paid at the time service is rendered. It is the patient's responsibility to check with their insurance regarding this fee. If the undersigned fails to keep current with these fees, a time pay account will be required to continue treatment. Thank you for your cooperation.

Signature: _____ Date: _____

HAVE YOU BEEN SEEN IN THIS PHYSICAL THERAPY DEPARTMENT BEFORE?
 YES _____ NO _____ IF YES, APPROXIMATE YEAR LAST SEEN _____

REFERRING PHYSICIAN: BRATBERG NOVOTNY ATWATER HAMM NORRIS
 CARMICHAEL HANSON PAUL OAKEY OTHER _____

NAME OF PRIMARY CARE PHYSICIAN: _____

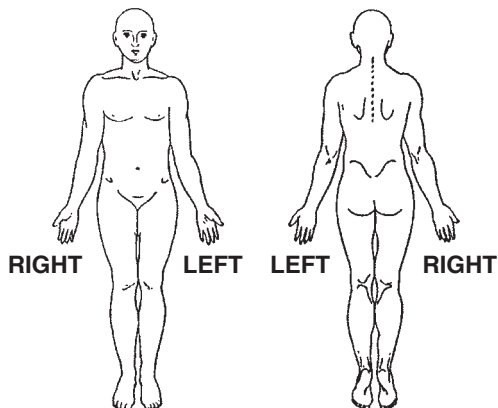
DATE OF INJURY OR ONSET OF SYMPTOMS: _____ / _____ / _____

HOW INJURY OCCURRED: _____

CURRENT MEDICATIONS:

PAST MEDICAL HISTORY: _____

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS: _____



PLEASE SHADE IN THE AREA ON THE DRAWING, WHERE YOU HAVE SYMPTOMS: _____

GOALS YOU EXPECT TO ACHIEVE FROM PHYSICAL THERAPY:

