Thank you for choosing Physical Therapy for Women!

Jennifer R. Shepherd, PT, CLT-LANA
Karen Moore, PT • Amanda Knauff, DPT, CLT-LANA
Jennifer Guardino, MSPT, CLT, CIDN • Jana A. Richardson, DPT
Brittany Reed, DPT, CLT • Taylor Ellis, PT • Michele Hardee, PTA
Jordan Rackley, PT, DPT, OCS • Jolea Myles, PTA

Date______________

Patient Name: ____
(First) (Middle) (Last)

Nickname: ____

Date of Birth: ___________________________ **Height:** ___________ **Weight:** _______

Address: ____
(Street)

____
(City) (State) (Zip code)

Home Phone: ________________ **Work Phone:** _______________ **Cell Phone:** ___________

Which is your primary phone? _________________

Would you like to receive appointment reminders: _________________

If yes, by text, voice or email _________________* **Note that PTFW does not encrypt emails**

Work Status: (circle one) Full time Part time Retired Disability Not Employed

Employer: ____

Student Status: (circle one) Not a student Full-time Student Part-time Student

Marital Status: (circle one) Married Single Other

Email address: ____

Would you like to be added to our email list? _____________________________________

Emergency Contact: ____
(Name) (Phone #)

Relationship to patient: ____

Referring Physician: ____

Return to Dr. Date: _______________________

Reason for PT evaluation: _______________________ **Date of first symptom**_____________

Primary Insurance____________________ **Secondary Insurance** ____________________

IMPORTANT: If you are currently receiving home health care , physical therapy, or chiropractic care, or have received physical therapy for any diagnosis this year, please let us know. This may affect your insurance coverage.

Please Check and sign below:

☐ I am not currently receiving home health care, physical therapy, occupational therapy, speech therapy or chiropractic care for any other diagnosis.

****From the list above which type of care are you currently receiving?

____

☐ I have read and understand the financial policy given to me by *Physical Therapy for Women, Inc.*

☐ I have read and understand the HIPAA Form.

☐ **MEDICARE PATIENTS** - Have you received physical therapy this year? If YES – How many visits did you attend? ____________________

____

Patient signature (for all items above) Date

☐ I would like a copy of *Physical Therapy for Women, Inc's* Financial Policy and/or the HIPAA Form.

☐ I authorize Physical Therapy for Women, Inc. to use my photographic image in marketing materials advertising our services that will be viewed by the general public. This includes PTFW's website, FaceBook page, and printed marketing materials.

I have read and agree with the above statement.

____

Signature Date

Physical Therapy for Women
Lymphedema and Pelvic Rehab Center
1630 Military Cutoff Road Suite 110
Wilmington, NC 28403
(910)798-2318

Patient Name: ____________________

DOB: ______________________

List of Current Medications

Name of Medication	Dosage	Frequency	Route

Allergies:____

____

Patient Signature____

Date_________________________