



Appointment Scheduled with: Dr. Hajek Dr. Thomas Dr. Lin Dr. Ganzel Physical Therapy Diagnostics

Name _____ Name you prefer to be called _____
(first) (middle) (last)

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell or Alt Phone # _____ Work Phone# _____

Is it ok to leave a message on your home phone? Y N Cell phone? Y N Work phone? Y N

Name of your family physician _____ Did your doctor refer you? Y N
May we confer with your family physician if needed? Y N

Who referred you to us: _____ Yellow Pages

Date of Birth _____ Male Female Marital Status S M W D SS# _____

Are you employed? Yes No Where are you employed? _____

In case of emergency contact _____ Relationship _____ Phone# _____

Name of person(s) we may discuss your health information with: _____

Local Pharmacy Name: _____ Address: _____

Do you have a mail order pharmacy? Y N If yes, what is the name: _____

Current Medications: _____

Medication Allergies: _____
(Please list any medicinal allergies including contrast dye, betadine, iodine and similar items)

What is the primary reason for your visit? _____

Is your visit the result of an accident? Y N If yes, Work Auto Home Date of injury _____

Were you injured on the job? Y N Is there or will there be litigation? Y N Date last worked _____

Attorney Name: _____ Address: _____

Have you previously been treated for this condition? Y N

If yes, when and by whom _____

Were X-rays, MRI, or CT scans obtained? Y N If yes, where? _____

DO YOU HAVE INSURANCE? Y N

****If insurance is NOT in your name, (example: if the Policy Holder is your spouse or parent) we MUST have:
(no exception's – if you do not know the insured's date of birth & social security # we cannot file your ins)**

Policy Holder's Name: _____ Policy Holder's Phone #: _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security # _____

Policy Holder's Address: _____ City: _____ St: _____ Zip: _____

Policies, Assignments, and Releases
I, the undersigned, am requesting treatment by Dr. Phillip Hajek, Dr. Frank Thomas, Dr. Ki-Hon Lin, Dr. Steven Ganzel, Kristen Busby, PA-C, Sheri Smith, PA-C, Suzanne Wilson, PT, and/or Teresa Bristol, PT, who are employees of Regional Health Group, Inc. I understand that while this is a practice offering orthopedic and physical therapy, no doctor desires to disrupt any current doctor patient relationship I may have, and I am free to choose my own orthopedist or physical therapist should any doctor here recommend such a referral. I further certify that I (or my dependent) have insurance with the company(s) or agency(s) provided, and I assign directly to Regional Health Group, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize my doctor(s) to release any information necessary to secure the payment of benefits or as needed to coordinate my care with other healthcare professionals. I authorize the use of this signature on all insurance claim submissions.

Please Sign Here _____ Date _____