

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT



Dear New Client:

We are pleased to be able to offer you the therapy services which you recently requested. You will find an admission form and release of information forms enclosed. It is important in beginning our work that these forms be filled out and sent back to us as soon as possible. Please stop by the office with your insurance card at the time of your first visit. We will need to photocopy the card for our records.

We also encourage you to check with your insurance company. Ask them specifically if they will cover therapy on an out-patient basis. When you contact your insurance provider you may want to refer to the insurance information page in the enclosed questionnaire. Please provide us with any details you may be aware of regarding your deductible, the portion of each therapy charge which will be your responsibility, any restriction on the number of therapy visits you may receive per year, and information about the role your primary care physician will play in ensuring therapy coverage.

In some cases insurance coverage is dependent upon specific data from your physician. It will be your responsibility to provide us with all documentation required by your insurance, such as: a diagnosis, a letter of medical necessity, a prescription – including frequency and duration of treatment, and a referral sheet or authorization number. Members of our office staff will be happy to help you coordinate information between your doctor and the insurance company, please feel free to bring to our attention any questions or concerns you may have. If your coverage requires co-payments, they will be due at the time of each visit.

We appreciate your choosing our clinic to serve you and look forward to meeting you. Thank you for your time spent completing these forms. This information will assist us on further accommodating you.

Sincerely,

Christine Weber, P.T.

Elaine Sianis, PT

Christine Weber/Elaine Sianis
Executive Directors

3105 N. Wilke Rd., Arlington Heights, IL 60004
847-255-8690 Fax 847-255-2260

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ADMISSION FORM

PATIENT IDENTIFICATION

Patient's Name _____ M ___ F ___ Date of Birth _____
Home Address _____ Home Phone _____
City/State _____ Zip Code _____

Primary Care Physician _____ Phone _____
Address _____
City/State _____ Zip Code _____ Fax _____

School Patient Attends _____
Address _____ Phone _____
City/State _____ Zip Code _____

FAMILY INFORMATION

Email Address: _____
Father's Name _____ **Date of Birth** _____
Home Address (if different) _____
Home Phone (if different) _____ Cell Phone _____

Email Address: _____
Mother's Name _____ **Date of Birth** _____
Home Address (if different) _____
Home Phone (if different) _____ Cell Phone _____

Legal Guardian (if different) _____ Phone _____
Home Address _____
City/State _____ Zip Code _____

INSURANCE INFORMATION

Name of Insured _____ Date of Birth _____
Insurance Co _____ ID# _____ Group # _____
Type of Insurance: PPO ___ POS ___ HMO ___ Other ___ Secondary Policy: Yes ___ No ___

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Patient's Name _____

HEALTH AND MEDICAL HISTORY

1. What is and has been the your general health history? _____

| Illnesses / Conditions? | Date | Severity | Medication |
|-------------------------|-------|----------|------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

3. Do you have any known allergies? _____ If so, to what? _____
Reactions? _____ Treatment? _____

4. Have you had any convulsions (seizures)? _____ If so, when was the last one? _____
Are you currently on medications for this? _____ What medications? _____

5. Please list any hospitalizations.

| Date | Reason | Duration | Hospital |
|-------|--------|----------|----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

6. Please list any accidents.

| Type of Accident | Date | Treatment |
|------------------|-------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

7. Please describe any complications that occurred during any of the above hospitalizations or accidents.

8. Were any of the above hospitalizations or accident followed by noticeable changes:

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Patient's Name: _____

9. Are you currently on any form of medications other than for above illnesses or conditions?
_____ If so, list medication and why:

10. Is there any history of neurological, hearing, psychological or hereditary problems in the immediate family or mother or father's families? _____ If so, please describe. _____

11. Have there been any pregnancies? _____

Did you experience any unusual illness, condition or accident, such as German Measles, Rh incompatibility, false labor, anemia, bleeding, diabetes, etc? If so, please describe.

Describe any medical attention you required. _____

OTHER EXAMINATIONS

Please indicate below other exams and/or treatment you received. Please include location, date, doctor/therapist, results and recommendations.

ADDITIONAL INFORMATION

If there is any additional information that you feel will help us to understand you and your problem better, please describe:

