PRIORITY MEDICAL & REHAB CENTERS

"Your Health is our Priority"

PATIENT INFORMATION **Date:**_____

Name:_____ Home Phone:_____

Email address:_____ Cell Phone:_____

Address:_____Apt. #___ City/State _____Zip Code_____

Employer/Occupation:_____ Work Phone:_____

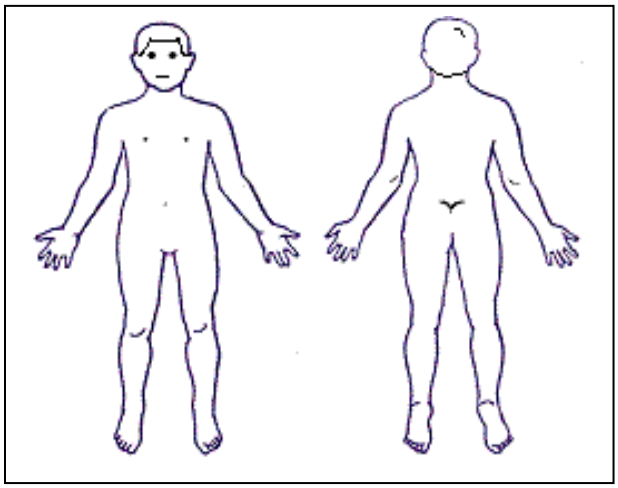
Work Address:_____ City/State _____ Zip Code_____

Age _____ Date of Birth _____ Marital Status: M S D W

Emergency Contact:_____ Phone:_____

How long are you at the above home address? _____

MARK AREAS OF PAIN/DISCOMFORT ON THE DIAGRAMS BELOW



MAJOR COMPLAINT
(Please describe only your major problems)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is today's problem caused by: ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER: _____

When was the first time you were aware of this problem? _____

Have you had this problem or similar problem before? If YES, please explain: _____
_____

Have you ever received any treatment for this condition? (hospital, outpatient facility, etc.) □ YES □ NO If YES, where and when, and what were the results? _____

10778 Wiles Road Coral Springs, Florida 33076 **Phone: 954-346-5750 Fax: 954-757-2533**

www.prioritymedicalrehab.com

Is there anything you do that makes your condition worse? _____

Have you ever been in an automobile accident? □ Past Year □ Past 5 Years □ Over 5 Years □ Never

Do you have an attorney? Yes No Name _____ Phone # ( )_____

Describe any previous surgeries _____
_____

Are you pregnant □ YES □ NO

Drugs you now take: □ Nerve Pills □ Pain Killers □ Muscle Relaxants □ "Pep" Pills
□ Tranquilizers □ Insulin □ Birth Control Pills □ Others (please list) _____

Have you ever suffered from:					
Dizziness	____	Headaches	____	Sinus trouble	____
Backaches	____	Numbness	____	Anemia	____
Heart Trouble	____	Asthma	____	Rheumatic Fever	____
Diabetes	____	Neuritis	____	Cancer	____
Tuberculosis	____	Digestive disorder	____	Other	____
Arthritis	____	Nervousness	____		

I understand that Priority Medical & Rehab Centers, LLC may contact me by mail, phone, e-mail or text messaging. **Initials**_____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Your Health insurance Company _____ ID # _____ or None ____

I understand and agree that health, automobile, and other insurance policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Priority Medical Centers, LLC d/b/a Priority Medical & Rehab Centers, LLC or its wholly owned subsidiaries will prepare any necessary reports and forms to assist me in making collection from the responsible insurance company and that any amount authorized to be paid directly to Priority Medical Centers, LLC d/b/a Priority Medical & Rehab Centers, LLC and its wholly owned subsidiaries will be credited to my account on receipt. I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, all fees for professional services rendered will be immediately due and payable. I was not solicited or persuaded by any person to seek services by Priority Medical Centers, LLC.

Patient's Signature: _____ **Social Security #** :_____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

*******IF YOURS IS AN ACCIDENTIAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS*******

Automobile Insurance Company_____ Policy # _____ or None_____

Date of Accident: _____ Hour: _____ □AM □PM Location: _____

If auto accident, were you □ DRIVER? □ PASSENGER? □ PEDESTRIAN? Vehicle Involved in accident? _____

If you were the DRIVER, please name any passengers:_____

Describe vehicle you own:_____ Describe any vehicle(s) owned by any members of your family in your current household: _____

At the time of the auto accident were you in the course of your employment? □ YES □ NO

Did you lose any wages as a result of your injury? □ YES □ NO

Date disability from work began:_____ Date returned to work:_____

Was your auto struck from □ Behind? □ Right side? □ Left side? □ Front? □ Auto was parked

Did your car strike the other(s) involved? □ YES □ NO

Did the other car strike yours? □ YES □ NO □ UNDETERMINED

Have you received or are you eligible for payment under Worker's Compensation of Unemployment? □ YES □ NO
If YES, amount per week:_____