

Case Type:  AA  PI  WC  MM  MC  PA

### **Patient Information**

Thank you for choosing Physicians Plus Berwyn. In order for us to complete records and submit accurate bills to your insurance company, please assist us by providing the following information.

Date: \_\_\_\_\_ SSN: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name: \_\_\_\_\_

Credit Card: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CID: \_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work/Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

Were you referred by:  Yourself  Friend  Ins. Carrier  PCP

### **Insurance Information:**

Insurance Company: \_\_\_\_\_ Primary Holder: Self Spouse Dependant Other

D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male / Female

Employer: \_\_\_\_\_

### **Work Comp / Auto Insurance / Attorney Information:**

Insurance Company: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Adjuster: \_\_\_\_\_

I understand and authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for all charges, which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**WHAT PROBLEM BRINGS YOU TO SEE US TODAY?**

WHEN DID THIS PROBLEM START? \_\_\_\_\_

WHAT CAUSED THIS PROBLEM? \_\_\_\_\_

If you were injured was it due to:  Work Accident  Auto  Personal Injury

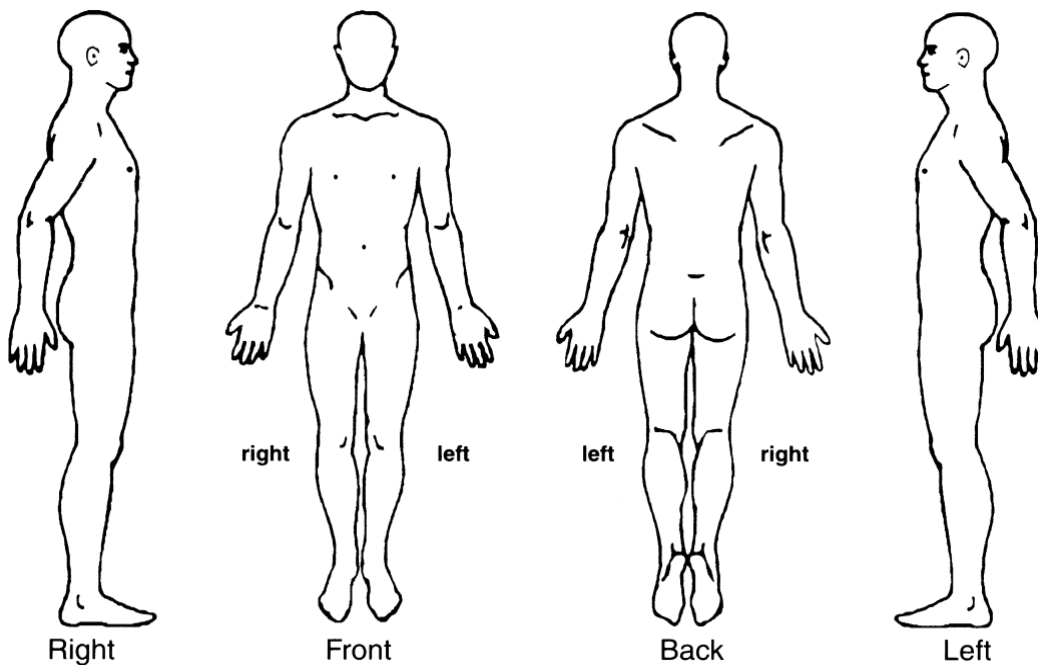
Describe your pain (Please Circle): Sharp Dull Achy Throbbing Numbness Pins/Needles

Intensity:  Mild  Moderate  Intense

Frequency: Constant Intermittent Only with Activity Other

If Other please explain: \_\_\_\_\_

**PLEASE CIRCLE/MARK THE AREAS OF PAIN ON THIS DIAGRAM:**



**INDICATE THE LEVEL OF PAIN ON A SCALE OF 1-VERY MILD → 10 – EXCRUCIATING**

AREA 1: \_\_\_\_\_

AREA 2: \_\_\_\_\_

AREA 3: \_\_\_\_\_

**SOCIAL AND FAMILY HISTORY**

Your current age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status: \_\_\_\_\_

**FAMILY MEMBERS:**

**AGE:**

**HEALTH STATUS:**

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have stairs in your residence that you must climb? \_\_\_\_\_

Are you able to feed / bathe yourself: \_\_\_\_\_

Do you require any special care or have any other concerns that might affect your treatment or recovery:? \_\_\_\_\_

If so, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY (HEART DZ, HTN, CANCER, STROKE ETC.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_