JOHN L. BRAUN, P.T., P.C.
PHYSICAL THERAPIST
2024 DEER PARK AVENUE
DEER PARK, NY 11729
TEL: (631) 243-0247
FAX: (631) 243-0248

Name _____

Date of Birth _____

Address _____

Phone: Home _____ Cell _____ Business _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

In case of emergency - notify _____

Phone # _____

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____
(If different from Primary)

Employer _____ Phone # _____

Address _____

Medications/Dosage _____

_____

_____

_____

Allergies _____

Height _____ Weight _____

Medical History:
(Please check all that apply to you)

☐ Hypertension
☐ Heart Disease
☐ Coronary Artery Disease
☐ Heart Attack
☐ COPD
☐ Congestive Heart Failure
☐ Seizure
☐ Asthma
☐ Stroke

Thyroid:
☐ Hyper ☐ Hypo

Diabetes:
☐ Type 1 ☐ Type 2

PRIMARY INSURANCE CARRIER _____

ID# _____ Copay _____

Carrier Address _____ Phone _____

Policy Holder:

Name _____ SS# _____ DOB _____

SECONDARY INSURANCE CARRIER _____

ID# _____ Copay _____

Carrier Address _____ Phone _____

Policy Holder:

Name _____ SS# _____ DOB _____

IS INJURY RELATED TO:

Workers Compensation: ☐ Yes ☐ No (Choose one)

No Fault Accident: ☐ Yes ☐ No (Choose one)

For Motor Vehicle Accident - Please complete the following:

Insurance Carrier _____ Phone _____

Address _____ Contact Person _____

Date of Accident _____ Policy Holder _____ Policy# _____

File# _____

Were you disabled? (Unable to work) ☐ Yes ☐ No (Choose one)

If you were disabled, please give dates: From _____ To _____

For Worker's Compensation - Please complete the following:

Insurance Carrier _____ Phone _____

Address _____ Contact Person _____

WCB# _____ Carrier Case# _____

Date of Injury _____ Time _____ Address _____

Describe how injury occurred _____

Were you disabled? (Unable to work) ☐ Yes ☐ No (Choose one)

If you were disabled, please give dates: From _____ To _____

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INFORMED CONSENT

I understand the risks and benefits of the physical therapy treatment as explained to me and I am in agreement with the treatment plan.

Patient's Name _____

Patient's Signature _____

Date _____

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AUTHORIZATION AND ASSIGNMENT

It is my understanding that if I become a patient in this office, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

I am authorizing you to release any information you feel appropriate concerning my condition to any insurance company, attorney, or adjustor in order to receive reimbursement on any charges incurred by me as a result of service rendered by you professionally.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize direct payment to you of any sum that I owe you now or in the future from any insurance company that is obligated to reimburse me to charges incurred in your office in part or full or my attorney out of the proceeds out of my settlement. A photocopy of this form is acceptable for payment.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign and give to you the right to take action against any insurance company that is obligated by contract to make payment to me. I authorize you to take action in either my name or your name to resolve this claim. It is understood that all reasonable efforts will be made to collect from the insurance company before I will be responsible for this bill. I do understand that whatever amounts are not collected from the insurance company, do become my responsibilify and I am to pay these charges as soon as possible. In the event that this office is forced to turn your account over to any attorney or collection agency for collection, you agree that you will be liable for all costs of collection including, but not limited to reasonable attorney fees. Interest will accrue on all accounts thirty (30) days past due at the rate of 16% annually.

_____

Signed

_____

Date

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Notice of Privacy Practices
Patient Acknowledgment of Receipt of Notice

This is to acknowledge that I have received and reviewed John L. Braun, PT, PC's Notice of Privacy Practices. Should I have any questions regarding the Notice of Privacy Practices, I understand that I can contact the Practice at (631) 243-0247.

_____ _____

Patient's Signature **Date**

FCE - Numeric Pain Scale

Patient Name:_____ Date:_____

Please rate your major area of pain on the 0 - 10 Pain Rating Scale by indicating the number that best describes your pain, considering the work descriptors next to the numbers, at the present time and your best and worst over the last 30 days.

☐ 10+	Maximal
☐ 10	very, very strong
☐ 9	
☐ 8	
☐ 7	very strong
☐ 6	
☐ 5	strong
☐ 4	somewhat strong
☐ 3	moderate
☐ 2	weak
☐ 1	very weak
☐ .5	very, very weak
☐ 0	nothing at all

My current pain rating is: _____

Is the pain (choose one): ◯ Constant ◯ Varies with Activity

My lowest/best pain rating is: _____

My highest/worst rating was: _____

What makes your pain better?

What makes your pain worse?