



## CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete the following information. Your answers will help us determine if our office can be of help to you. If we do not sincerely believe your condition will respond favorably, we will not accept your case. Thank you.

Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

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

Home/Cell Ph#: \_\_\_\_\_ Work Ph#: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: M S W D # Children: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

**How were you referred to our office (name)?** \_\_\_\_\_

Email Address: \_\_\_\_\_

### HEALTH INFORMATION:

What is your major complaint? \_\_\_\_\_

Other Complaints: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar condition in the past? Yes No

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse? Yes/No (Circle One) Constant Intermittent

Is this condition interfering with your: Work Sleep Daily routine other: \_\_\_\_\_

How long has it been since you felt really good? \_\_\_\_\_

Other doctors who treated this condition: \_\_\_\_\_

List surgical operations and year: \_\_\_\_\_

Medication you now take (include all vitamins): \_\_\_\_\_

Age of mattress: \_\_\_\_\_ (Circle One) Comfortable Uncomfortable

Are you wearing: (Circle One) Heel lifts Sole lifts Inner soles Arch supports

**Please complete the reverse side of this page**

**Have you been in an AUTO ACCIDENT?** Yes/No (Circle One) If so, when? \_\_\_\_\_

Describe: \_\_\_\_\_

Please provide the name of your auto insurance: \_\_\_\_\_ Claim#: \_\_\_\_\_

Is your condition due to an accident (other than auto)? **Yes / No** Date: \_\_\_\_\_

Please explain: \_\_\_\_\_

Attorney's info: \_\_\_\_\_ Ph #: \_\_\_\_\_

**On a scale of 1-10 (10 being the most and 1 being the least):**

**How committed are you to maintaining good health?** \_\_\_\_\_

Have you suffered from: (Circle All That Apply) Headaches, Backaches, Heart Trouble, Diabetes, Arthritis, Dizziness, Asthma, Neuritis, Digestive Disorders, Sinus Trouble, Neck pain

**HEALTH INSURANCE INFORMATION:**

Do you have health insurance? **Yes / No**

Name of Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_

Do you have a "pre-existing clause" on your policy? **Yes / No**

(If the answer is yes) Please list the non-covered conditions under this clause: \_\_\_\_\_

**Missed appointments without prior notice will result in a \$25.00 fee**

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable within 30 days of when notice has been given in writing. If this office is required to initiate collection procedures against a patient(s), then this office shall be entitled to reimbursement for their costs and the reasonable amount of attorney's fees incurred in seeking collection of the amounts due. In addition, this office reserves the right to place a charging lien on any monies or property, real or personal, recovered on the patient(s) behalf in connection with the case. I give Inline Sports Medicine & Rehab and its representatives permission to communicate to me via email, telephone or by mail via the contact information provided above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_

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