PATIENT DEMOGRAPHICS

1720 W.DR.MLK BLVD.
TAMPA, FL 6607
P(813) 876-7400 F(813) 877-8145

12/2016

SANTIAGO
THERAPY CENTER

Date: ____/___/____

Welcome to our office. This form must be filled out in its entirety.

PATIENT INFORMATION

Patient Name: _____

[ ] MALE [ ] FEMALE

DOB: ___/___/____ Age:_____ S.S.# _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Whom may we thank for referring you? _____

Primary Physician: _____

Phone # _____
E-mail: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____

Home Address: _____

City: _____ FL: _____ Zip: _____

Phone #: _____

Relationship: _____

EMERGENCY CONTACT

Name: _____

Phone: _____
Relationship: _____

INSURANCE INFORMATION

Front and Back copy of insurance card is REQUIRED

Primary Insurance: _____
Claims Address: _____

City: _____ Sate: ____ Zip: _____

Phone # _____

Insured Name (if different from patient): _____

ID # _____ Group # _____

Secondary Insurance _____

Claims Address: _____

City: _____ Sate: ____ Zip: _____

Phone # _____

Insured Name (if different from patient): _____

ID # _____ Group # _____

AUTO ACCIDENT (If applicable)

Date of Accident: _____

Insurance: _____

Claim #: _____

Insured Name: _____

Adjuster Info: _____

Adjuster #: _____

PAYMENT AUTHORIZATION

I hereby authorize payment of the insurance benefits covering all medical charges submitted by Santiago Therapy Center.

Patient Signature: _____

Guardian (if minor): _____

REFERRING PHYSICIAN: _____ Phone: _____
NPI: _____

MEDICAL HISTORY

1720 W. Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33607
P: (813) 876-7400 F: (813) 877-8145
www.santiagotherapycenter.com
A division of the J.A. Santiago MS, RPT, P.A.

	YES	NO		YES	NO
High Blood Pressure			Gallbladder Disease		
Heart Disease			Liver Disease		
Rheumatic Fever			Kidney Disease		
Chest Pain			Arthirits		
Irregular Heart Beat			Cancer		
Shortness of Breath			Anemia		
Stroke			Low Back Pain		
Swelling of Feet			Gout		
Frequent Headaches			Ulcers		
Epilepsy			Constipation		
Depression			Chronic Diarrhea		
Suicide Attempt			Asthma		
Psychiatric History			Allergies		
Phlebitis			Dizziness		
Fainting			Alcoholism		
Drug Addiction			Birth Defects		
Jaundice			Neck Pain		
Diabetes			Hemophilia		
Prosthetic Joints			Blood Disorders		
Metal in your body			Pregnant		

If you answered YES to any of the above, please explain:

_____
_____
_____
_____
_____
_____

Signature: _____ Date:_____

SANTIAGO
THERAPY CENTER

MEDICAL CONSENT FORM

1.) MEDICAL CONSENT: The patient is under the care of Santiago Therapy Center and the undersigned consents to any x-ray, examination, laboratory procedures, diagnostic service, or other services rendered the patient under the general and specific instructions of Santiago Therapy Center.

2.) CONSENT TREATMENT: I hereby agree to the performance of treatment services as in the opinion of my physical therapist are deemed necessary.

3.) RELEASE OF INFORMATION: Santiago Therapy Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to Santiago Therapy Center or to the patient or to a family member or employer of the patient for all or part of the medical charges, including, but not limited to medical service companies, workers' compensation carriers, welfare funds or the patient's employer.

4.) ASSIGNMENT OF BENEFITS: In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient said benefits are hereby assigned to Santiago Therapy Center for application on patient's bill, and it is agreed that Santiago Therapy Center may receive any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and or patient being responsible for charges not covered by this assignment.

5.) FINANCIAL AGREEMENT: The undersigned agrees whether he signs as agent or as patient that in consideration of the services to be rendered to the patient, the hereby individual obligates himself to pay the account in accordance with the regular rates and terms of the facility. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection fees and collection expenses. A 0.1% service charge will be assessed on all account balances past 30 days. Any dispute will be resolved in our Jurisdiction.
The undersigned certifies that he has read the foregoing, is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept the terms.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature Date

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST AUTHORIZE TREATMENT TO BE ADMINISTERED TO PATIENT.

PATIENT INJURY IDENTIFICATION

SANTIAGO
THERAPY CENTER

1720 W. Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33607
P: (813) 876-7400 F: (813) 877-8145
www.santiagotherapycenter.com
A division of the J.A. Santiago MS, RPT, P.A.

Name:_____

Please fill in the following information to accurately evaluate and treat. Draw or shade in the location of your body injuries as a result of your most recent accident. Describe by connecting a line to the body diagram.

Note pain, stiffness, weakness, numbness, cuts, black and blue marks, swelling, scars, etc. Carefully scan your entire body pushing on areas to note tenderness and move arms, legs, back, etc. Include pain during activities such as lifting, bending, working, etc. This is very important so the doctor can concentrate and not overlook any injuries

SANTIAGO
THERAPY CENTER

1720 W. Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33607
P: (813) 876-7400 F: (813) 877-8145
www.santiagotherapycenter.com
A division of the J.A. Santiago MS, RPT, P.A.

MEDICAL RECORD RELEASE

Date: _____/_____/_____

Requesting from: _____

Patient name: _____

Attention: _____

Patient D.O.B.: _____/_____/_____

Phone: _____

Social Security #: _____

Fax#: _____

Comments:

_____
_____
_____
_____

Dates of service: from _____ to _____

I hereby authorize the release of my medical records, X-rays and any other pertinent information related to myself, the patient, to Santiago Therapy Center, for the provision of care and obtaining reimbursement.

_____
Patient Signature

_____
Guardian Signature (if patient is underage)