Trinity Wellness Center

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Patient Information

Account #	Social Security #	Title	Last Name	First Name	MI

Street Address (Road or Street)	(Apartment Number or Second Address Line)

Zip Code	City	State	Home Phone:

Cell Phone:	Email Address:	Patient Data: (Nick Name)

Birthday	Sex (M, F)	Referring Doctor full name	Reason for Referral

Marital	Employment	Student	Relationship to Insured
☐M-Married ☐ W-Widowed ☐S-Single ☐D-Divorced ☐ X-Separated	☐ R-Retired ☐ F-Full ☐P-Part ☐ N-None	☐ P-Part ☐ F-Full ☐ N-None	☐SE-Self ☐SP-Spouse ☐OT-Other ☐CH-Child

Employer Name

Employer Street Address (Road or Street)

Zip Code	City	State	Business Phone	Ext

INSURANCE INFORMATION

Primary Insurance Company Name Mailing Address

Insurance Telephone # Policy # Group #

Secondary Insurance Company Name Mailing Address

Secondary Telephone # Policy # Group #

COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME

Social Security #	Title	Last Name	First Name	MI

Birthday	Sex (M, F)	Relationship to Insured:

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related:	Accident Related:	Date of first symptom or accident:
☐ Yes ☐ No	☐ Auto ☐ Other ☐ No	

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.

Signed Date

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed Date

Trinity
WELLNESS CENTER

200 Horizon Drive, Suite 115, Raleigh, NC 27615
Phone: 919-875-1932 ▪ Fax: 919-875-1933
E-mail: admin@trinitywellnesscenter.net

CANCELLATION/NO SHOW POLICY

Patient/Guardian: _____ DOB: _____

Twenty-four hour notice of a cancellation is requested so that other patients needing services may be notified in time to fill any available slots. In the case of an unexpected change of schedule, please call and notify us of need to cancel as soon as possible. Recurrent late cancellations or no-show appointments will be subject to a **$40 fee.** In the event of multiple occurrences of this, Trinity Wellness Center reserves the right to discontinue services.

We are committed to providing high-quality services and are dedicated to providing you a one-on-one appointment each time you come in. Because of this commitment, we kindly ask that you respect our time and the needs of other patients by cooperating with this policy.

The undersigned acknowledges the Trinity Wellness Center cancellation/no show policy and understands that a $40 fee will be imposed when appointments are missed without prior notice.
I acknowledge that in the event of multiple occurrences of this, Trinity Wellness Center reserves the right to discontinue providing services.

Signature of Patient/Guardian: _____ Date: _____

Financial Policy and Admission Agreement
Certification of Receipt of Notice of Privacy Practices

Consent for Services:
I hereby authorize the staff of Trinity Wellness Center to administer physical therapy services as ordered by my physician (physician's orders not necessary for self-pay patients) and as described in my plan of care.

Consent for Services for Minor:
I hereby authorize the staff of Trinity Wellness Center to administer physical therapy services as ordered by the ordering physician (physician's orders not necessary for self-pay patients) and as described in the plan of care. I understand that minors over age 16 do not require my presence and I authorize Trinity Wellness Center to administer physical therapy services without my being present.

Assignment of Benefits:
I certify that the information given by me in applying for payment from my insurer is correct. I request that payment of authorized benefits be made on my behalf to Trinity Wellness Center, Inc. I understand that I am fully responsible to Trinity Wellness Center for all charges not paid by my insurer within 60 days.

Notice of Privacy Practices:
I acknowledge receipt of a copy of the Trinity Wellness Center Notice of Privacy Practices and understand how my protected health Information may be used and disclosed by this office. I understand my rights as a patient and authorize Trinity Wellness Center to disclose my protected health information as explained in this notice.

Furthermore, I hereby authorize the below designated parties (spouse, family member, etc.) to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to my treatment. I understand that the identity of designated parties must be verified before the release of any information.

The undersigned acknowledges receipt of the Trinity Wellness Center Financial Policy and Admission Agreement; and understands the patient rights and responsibilities. The undersigned agrees to the policies above regarding payment; and agrees that if this account becomes delinquent and requires collection service, all reasonable collection and handling charges will be added to the outstanding balance after 30 days.

Patient Name (Please Print):_____

Guardian Name/Signature (if patient is minor):_____

I would like to receive appointment reminder messages via (Please Circle) Email Text Both

I give permission to leave messages on voicemail (Please Circle) Yes No

I give permission to discuss medical condition, appointments or account with below designated people:

Emergency Contact: _____ Relationship:_____ Phone _____

Authorized Designee: _____ Relationship:_____ Phone _____

Signature of Patient/Guardian: _____Date:_____

Witness: _____ Date: _____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Currently not taking any medications