



# THE CENTER FOR MANUAL MEDICINE

&

# REGENERATIVE ORTHOPEDICS

*"We help you, help yourself"*

Doug Frye MD,RMSK— Regenerative Orthopedics  
Dani D. Steffen, DC—Chiropractic  
C. Matt Elniff PT, FAAOMPT— Physical Therapy  
Courtney Simon PT—Physical Therapy  
Seth Harrison, CSCS- Clinic Manager

5000 SW 21ST STREET  
TOPEKA, KS 66604  
PHONE: 785-271-8100  
FAX: 785-271-9257  
WEBSITE: www.ctmrm.com

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## CONFIDENTIAL PATIENT CASE HISTORY

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Birthdate: \_\_\_\_\_ Race: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: M \_ S \_ W \_ D \_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Number: \_\_\_\_\_

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

How would you prefer to be contacted for our Appointment Reminders? Call \_\_\_\_ Text \_\_\_\_ Preferred Contact Number: \_\_\_\_\_

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

### Spouse/Significant Other:

Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance:** \_\_\_\_\_

Cardholders Name: \_\_\_\_\_ Card holders DOB: \_\_\_\_\_

### Emergency Contacts:

1) Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone #: \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone #: \_\_\_\_\_

### General Information:

How did you hear about us? \_\_\_\_\_ Were you referred? YES NO By whom? \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Do you give us permission to discuss your records with someone else? YES NO

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

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

Is your condition due to an active Motor Vehicle Accident (MVA), Worker's Compensation (WC), or Personal Injury Claim? YES NO

If yes please explain:

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

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**I UNDERSTAND & AGREE THAT HEALTH & ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER & MYSELF. FUTUREMORE, I UNDERSTAND THAT THE CENTER FOR MANUAL MEDICINE & REGENERATIVE ORTHOPEDICS WILL PREPARE ANY NECESSRY REPORTS & FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I UNDERSTAND & AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME & THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT SHOULD MY INSURANCE NOT COVER MY TREATMENT.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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