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.ctrmm.com

****

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 your 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:

_____

_____

****

I UNDERSTAND & AGREE THAT HEALTH & ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER & MYSELF. FUTHERMORE, 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: _____