Progressive Spinal and Sports Rehabilitation, P.C.
15200 Shady Grove Road, Suite 211 Rockville, MD 20850

Dr. John H. Park
(240) 477-8719

Welcome to our office!

Patient Information

Date: _____
Patient Name: _____
Address:_____
_____
Sex: ☐ M ☐ F Age:_____ DOB:_____
☐Single ☐Married ☐Divorced ☐Separated
Patient SSN:_____
Occupation:_____
Name of Employer:_____
Employer Address:_____
_____
Whom may we thank for referring you?
_____
Your email address:
_____

Home # :_____Cell # :_____
Work # :_____ext_____

Would you like to be contacted by email, text message or phone for your appointment reminder? Please circle one.

Spouse's Name:_____
DOB:_____
Occupation:_____
Name of Employer:_____

IN CASE OF EMERGENCY, CONTACT:
Name:_____
Relationship:_____
Home # :_____ Other # :_____

Insurance Information

Who is responsible for this account?_____
Relationship to patient:_____
Policy Holder's DOB:_____
SSN:_____
Insurance Company:_____
Policy/Member # :_____
Group # :_____
Is patient covered by additional insurance?
☐Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to Dr. John H. Park, an insurance benefits, if any, otherwise I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions.

_____
Responsible party signature

_____ _____
Date Relationship to patient

Accident Information

Is condition due to an accident? ☐ Yes ☐ No
Date of Injury: _____
Type of Accident:☐ Auto ☐ Work
☐ Home ☐ Other
How were you injured?_____
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Work Comp
☐ Other:_____
Name of Attorney (if applicable):_____
Phone # :_____

Patient Condition

Reason for Visit?_____
When did your symptoms appear?_____
Is this condition getting progressively worse? ☐ Yes ☐No ☐ Unknown
Rate the severity of your pain on a scale of **1** (least pain) to **10** (severe pain):_____
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching
☐Shooting ☐ Burning ☐Tingling ☐Cramps ☐ Stiffness ☐ Swelling
☐ Other_____
When do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐ Recreation
Activities/movements that are painful to perform: ☐Sitting ☐ Standing ☐Walking
☐Bending ☐Lying down

Mark an **X** where you feel symptoms: