

Healing and Wellness Center of Kent Island

Dr. Kristin Mowry, DPT

Physical Therapy ❖ Nutrition ❖ Health Supplies

Correspondence Address:

501 Wye Narrows Drive
Queenstown, MD 21658
Fax (410) 604-0960

Office Location:

711 Main Street
Stevensville, MD 21666
Phone (410) 604-0900

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ E-mail address: _____

Address: _____ City, State, Zip: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____ Work Phone: () _____ - _____

D.O.B. _____ Age: _____ Social Security Number: _____ - _____ - _____ Sex: M F

Height/Weight (optional): _____ Marital Status: _____

Name of Emergency Contact (relation): _____ Phone: () _____ - _____

How did you find out about Dr. Mowry? OR Who referred you? _____

Is your visit here due to an accident? yes no

If yes, when and where did this accident take place? _____

What is your present complaint? _____

Briefly describe your symptoms _____

How long has this pain persisted? _____

How do you ease this pain yourself? _____

On a pain scale from 1-10 (10 being the worst, 1 being the least) How bad is your current pain? ____/10

Please list any other doctor(s) and their location(s) that you have seen to treat this condition: _____

Medical History- If any of the following are relevant to your history, please check the appropriate boxes:

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infections | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Leaking (urine) |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Allergies | <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches or Migraines | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weight Loss or Gain | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Food Cravings |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Other (Please explain): _____ | | | |

Please describe any operations that you have had (include dates): _____

Have you been treated by a physician for any health condition in the past year? yes no

If yes, please explain: _____

Are you currently taking medication? yes no If yes, please list the medication and the reason for taking that medication: _____

Are you allergic to any medication? yes no If yes, what kind? _____

Are you pregnant? yes no

If you have medical insurance: Insurance Company: _____ Policy #: _____

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree what all services rendered to me will be immediately due unless prior arrangements have made. I hereby authorize the doctors at The Healing and Wellness Center of Kent Island and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's Signature: _____ Date: _____
(Parent or Guardian if under 18 years of age)

H I P A A

I understand that the doctors and employees of The Healing and Wellness Center of Kent Island obey all laws relating to patient confidentiality and HIPAA. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that I may request a copy of, and will be provided, the HIPAA rules, standards, and guidelines at anytime while I am receiving treatment at this facility.

Patient's Signature: _____ Date: _____
(Parent or Guardian if under 18 years of age)