New Patient Information Form

First Name: ______________________________MI: _____ Last: ____

Address: __________________________________City: _________________State: ________Zip: _______________

Date of Birth: ______________Home Phone: ________________________Cell Phone: _______________________

Primary Phone? Home Cell How do you prefer to have reminders sent? Phone Text Email

SSN: ______________________________Email Address: ____

Employer: ___________________________________ Employer Phone: ____________________________________

General Physician: ____________________________ Referring Physician: _________________________________

Emergency Contact: ____

Relationship: _________________________________ Emergency Contact Phone: __________________________

<u>Please provide the following information:</u>

Primary Insurance: ___________________ Policy Holder Name: _________________Date of Birth: ___________

Relationship to Patient: _______________ Policy ID #: _________________ Group #: _______________________

Secondary Insurance: _________________ Policy Holder Name: _________________Date of Birth: __________

Relationship to Patient: _______________ Policy ID #: _________________ Group #: _______________________

Is this work-related? Yes No If yes, date of injury: ____

Is this related to a Motor Vehicle Accident? Yes No If yes, date of injury: _____________________________

How did you hear about us? Physician Referral Family or Friends Industry Social Media

Advertisement (please list form): _________________Other (please list): _________________________________

CANCELLATION & NO-SHOW POLICY: We require a 24-hour notice in the event of a cancellation. The charge for cancellation without proper notice is $25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. Any future appointments may be automatically cancelled and 2 “no-show” appointments may result in discharge from physical therapy. NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be a subject to a $25 processing fee.

Employee Initial: __________ Patient Initial: __________

CONTACT INFORMATION: By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

I hereby give consent for treatment for myself, or the named minor child, by the staff at Physical Therapy Plus and/or as directed by my referring physician. I authorize the release of any information necessary to process claims for these services. I authorize the release of clinical information for treatment, payment, and healthcare operations. I assign medical benefits payable for these services directly to Physical therapy Plus. I understand that I am responsible for payment of any applicable co-payment, co-insurance, and deductibles at the time of service. In signing this form,   I understand that I am responsible for the bill not paid by my insurer

Patient/Guardian Signature: ________________________________Date: ____________

Patient Initials: ________I have been given the Notice of Privacy Practice, and I have been made aware, and copies have been made available to me of the rights. If I have any questions I can contact the Compliance Officer at 502-845-0005.

Medical History and Previous Treatment

Patient Name: ________________________________

Please check if you have been diagnosed with any of the following conditions:

____ Diabetes	____ Heart disease	____ High blood pressure	____ Cancer
____ Pacemaker	____ Stroke (TIA/CVA)	____ Seizures	____ Metal implants
____ Back pain	____ Circulation problems	____ Osteoporosis	____ Stomach ulcers
____ Broken bones	____ Respiratory problems	____ Depression	____ Kidney disease
____ Blood clots	____ Rheumatoid arthritis	____ Thyroid problems	____ Allergies

____ Infectious diseases (HIV, Hepatitis B, Hepatitis C, TB, etc.)

Other: ____

Surgical History: ____

During the past month, have you been feeling down, depressed, or hopeless? YES   NO

Please list all medications you are currently taking (prescribed and over-the-counter):

____

____

Have you recently noted?

YES	NO	Weight loss/gain	YES	NO	Nausea/vomiting
YES	NO	Dizziness/lightheadedness	YES	NO	Unusual weakness
YES	NO	Fever/chills/sweats	YES	NO	Visual problems
YES	NO	Incontinence	YES	NO	Hearing problems
YES	NO	Bleeding	YES	NO	Pregnant or think you are pregnant
YES	NO	Speech difficulty	YES	NO	Loss of balance

Date of onset of current symptoms/injury: Month: ________Day: _______Year: __________

Have you had the same or a similar problem in the past? YES NO

If yes, please provide more detail explain: ____

Please explain any treatment you have received (or currently receiving) for this problem, such as previous physical or occupational therapy, chiropractic visits, etc. ____

____

Have you received X-rays, MRI, CT Scan, Bone Scan, etc. for this problem?

____

Has your doctor discussed your medical findings or given you a diagnosis? YES NO

If yes, what were the findings? ____

If yes, what is the doctor's name? ____

What are your goals for recovery____

Are you aware of any physical reason why you should not receive treatment? YES NO

If yes, please tell us what it is: ____

What is your Height? ________________________ What is your Weight? __________________________________

To the best of my knowledge, the above information is accurate and complete.

Signature: ____Date: ____________________