Patient Information

(THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO PROPERLY FILE YOUR INSURANCE)

PERSONAL INFORMATION

NAME: ________________________________ SSN#: __________________________ D.O.B. ____________________

ADDRESS ______________________________________ CITY ________________ ST ______________ ZIP ________

PRIMARY PHONE# _______________________________ SECONDARY PHONE# _______________________________

PRIMARY PHYSICIAN _____________________________ CITY ______________________ PHONE# ________________

SINGLE ________ MARRIED __________ OTHER _____________

RETIRED: YES _______ NO _______ (If no please complete the information below)

EMPLOYER NAME ____

EMPLOYER ADDRESS ______________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________ INSURANCE ID# ______________ INSURANCE GROUP# ___________

INSURED/MEMBER NAME ____

RELATIONSHIP: SELF ___________________ SPOUSE _____________ CHILD ______________ OTHER ________________

INSURED/MEMBER DOB ____________________________ INSURED/MEMBER SSN# _____________________________

SECONDARY INSURANCE ____________________ INSURANCE ID# _____________ INSURANCE GROUP# ___________

INSURED/MEMBER NAME ____

RELATIONSHIP: SELF ___________________ SPOUSE _____________ CHILD ______________ OTHER ________________

INSURED/MEMBER DOB ____________________________ INSURED/MEMBER SSN# _____________________________

PATIENT SIGNATURE ____ **DATE** ______________________

PAST MEDICAL HISTORY FORM PAGE 1

NAME____DATE___________________________

(IN ORDER TO HAVE THE BEST UNDERSTANDING OF YOU CONDITION, PLEASE CIRCLE ALL ISSUES THAT APPLY TO YOUR HEALTH)

	GENERAL
	CANCER
	CHRONIC PAIN
	DEPRESSION
	FATIGUE
	FEVER
	NERVOUSNESS
	PANIC ATTACKS
	TROUBLE SLEEPING
	WEIGHT LOSS/GAIN
	ANEMIA
	HEART
	HIGH BP
	HEART TROUBLE
	HEART SURGERY
	HEART MURMUR
	CHEST PAIN or ANGINA
	PALPITATIONS
	PACEMAKER
	PERIPHERAL VASCULAR DISEASE
	RHEUMATIC FEVER
	HAVE YOU NOTICED
	FATIGUE
	LETHARGY
	WEAKNESS
	DIFFICULTY SWALLOWING
	DIZZINESS
	LIGHTHEADED
	CHILL/FEVER
	NUMBNESS
	DIGESTIVE
	NAUSEA
	WEIGHT LOSS
	WEIGHT GAIN
	VOMITING

	ENDOCRINE
	DIALYSIS
	EXCESSIVE SWEATING
	EXCESSIVE THIRST/HUNGER
	EXCESSIVE URINATION
	HEAT OR COLD INTOLERANCE
	DIABETES
	THYROID TROUBLE
	HEPATITIS
	EYES
	CATARACTS
	DOUBLE VISION
	GLAUCOMA
	POOR VISION
	GLASSES
	LUNGS
	ASTHMA
	BRONCHITIS
	EMPHYSEMA
	PNEUMONIA
	TROUBLE BREATHING
	WHEEZING
	TUBERCULOSIS
	EARS
	CLOGGED EARS
	EAR INFECTION
	EAR PAIN
	EAR SURGERY
	HEARING LOSS
	TINNITUS/RINGING

	NEUROLOGIC
	FAINTING
	MEMORY LOSS
	PARALYSIS
	SEIZURE DO
	STROKE
	TREMORS
	EPILEPSY
	ENCEPHALITIS
	DIZZINESS/VERTIGO
	HEAD AND NECK
	PAIN
	CONCUSSION
	HEAD INJURY
	HEADACHES
	MENINGITIS
	NECK PAIN
	NOSE & THROAT
	ALLERGIES
	SINUS TROUBLE
	MUSCULOSKELETAL
	RHEUMATOID ARTHRITIS
	BACK INJURY
	JOINT PAIN/INJURY
	WEAKNESS
	POOR BALANCE
	CRAMPS
	LETHARGY
	HISTORY OF FALLS
	NUMBNESS/TINGLING
	BACK ACHE/ STIFFNESS
	OSTEOPOROSIS
	JOINT REPLACEMENT
	GOUT
	SWELLING

PAST MEDICAL HISTORY FORM PAGE 2

NAME____DATE__________________________

MEDICATION NAME	DOSE	HOW LONG & HOW OFTEN DO YOU TAKE THE MEDICATION

PLEASE LIST DATES & TYPES OF SURGERIES YOU HAVE UNDERGONE:

____

____

____

PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU MAY HAVE:

____

____

____

PLEASE LIST DATES & TYPES OF ACCIDENTS/INJURIES YOU MAY HAVE SUFFERED:

____

____

____

PAST MEDICAL HISTORY FORM PAGE 3

CHECK ANY OF THE FOLLOWING WHOSE CARE YOU ARE UNDER:

☐ PRIMARY CARE DOCTOR ☐ NEUROLOGIST ☐ PSYCHIATRIST / PSYCOLOGIST

☐ CHIROPRACTOR ☐ EYE DOCTOR ☐ ENT (EAR NOSE THROAT, MD)

☐ PHYSICAL THERAPIST ☐ OTHER___________________________________

IF YOU'VE SEEN ANY OF THE ABOVE CAREGIVERS IN THE LAST 3 MONTHS, PLEASE DESCRIBE THE REASON (REGULAR CHECK-UP / PHYSICAL, ILLNESS, MEDICAL CONCERN ETC.)

____

____

____

____

DURING THE PAST MONTH HAVE YOU BEEN FEELING DOWN, DEPRESSED OR HOPELESS? YES____NO____

DURING THE PSAT MONTH HAVE YOU BEEN BOTHERED BY HAVING LITTLE INTEREST OR PLEASURE IN DOING THINGS? YES______NO_____

DO YOU EXERCISE REGULARLY? YES______NO_______

TYPES OF EXERCISE YOU ENJOY: ____

PLEASE INDICATE YOUR GOAL IN COMING TO PHYSICAL THERAPY:

____

____

____

____

____

____

____

____

PATIENT CONSENT TO RECEIVE MAIL, EMAIL & OR TEXT MESSAGES

____

LAST NAME FIRST NAME MIDDLE INITIAL

____

HOME PHONE WORK PHONE CELL PHONE

EMAIL ADDRESS____

EMERGENCY CONTACT_______________________________PHONE_______________________

RELATIONSHIP TO PATIENT____

DO WE HAVE PERMISSION TO?

SEND A YEARLY APPOINTMENT REMINDER TO YOUR HOME? **YES / NO**

SEND MEDICAL RECORDS/TEST RESULTS TO YOU? **YES / NO**

LEAVE APPOINTMENT INFORMATION ON YOUR ANSWERING MACHINE? **YES / NO**

LEAVE BILLING INFORMATION ON YOUR ANSWERING MACHINE? **YES / NO**

COMMUNICATE MEDICAL UPDATES, APPOINTMENTS, BILLING, MEDICAL OR OTHER INFORMATION VIA EMAIL? **YES / NO**

I GIVE MY PERMISSION TO SHARE APPOINTMENT INFORMATION WITH THE PEOPLE NAMED BELOW:

____

I GIVE MY PERMISSION TO SHARE MEDICAL INFORMATION WITH PEOPLE NAMED BELOW:

____

PATIENT SIGNATURE_______________________________________DATE__________________

PRINT NAME OF PATIENT
OR REPRESENTATIVE: ______________________________________DATE__________________

MEDICARE SIGNATURE AUTHORIZATION - FOR SERVICE BEGINNING _______________, I AUTHORIZE **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC** TO RELEASE MEDICAL OR OTHER INFORMATION ABOUT ME TO SOCIAL SECURITY ADMINISTRATION & HEALTH CARE FINANCING ADMINISTRATION, ITS INTERMEDIARIES, OR CARRIES FOR BENEFIT CLAIMS & REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO BE MADE TO **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC.**

SIGNED ______________________________________DATE____________________________

INSURANCE AUTHORIZATION - FOR SERVICE BEINGING____________________, I AUTHORIZE **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC** TO RELEASE MEDICAL OR OTHER INFORMATION ABOUT ME TO MY INSURANCE CARRIER(S) FOR BENEFIT CLAIMS SUBMITTED ON MY BEHALF. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO BE MADE TO **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC.**

SIGNED ______________________________________DATE____________________________

TERMS OF PAYMENT FOR RENDERED - I HEREBY AUTHORIZE & REQUEST THAT ALL PHYSICAL THERAPY INSURANCE BENEFITS BE PAID DIRECTLY TO **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC** FOR SERVICES AND ITEMS PROVIDED. I SHALL ACCEPT LEGAL RESPONSIBILITY FOR THE TOTAL FEE DUE, & I UNDERSTAND AND AGREE THAT ANY UNPAID BALANCE WILL BE PAID BY ME EVEN IF THE INSURANCE ALLOWANCE FOR THE SERVICE IS LESS THAN FEE CHARGED. OUR STANDARD FEES WILL BE ADJUSTED TO THE ALLOWABLE FEE SCHEDULE SET BY THE INSURANCE. CONTRACTS IN WHICH WE PARTICIPATE. THIS INCLUDES COLLECTION AGENCY FEE NECESSARY IN COLLECTING A BALANCE OWED BY ME TO **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC.** I ALSO CONSENT TO PAY RETURN CHECK FEES FOR EACH CHECK IN THE EVENTI PRESENT A CHECK THAT IS RETURNED BY MY NAME FOR HAVING INSUFFICIENT FUNDS.

SIGNED ______________________________________DATE____________________________

HIPAA - WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. BY MY SIGNATURE I ACKNOWLEDGE THAT I HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICE, WHICH DESCRIBES THE TYPES OF USES DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT WILL OCCUR IN MY TREATMENT, PAYMENT OF MY BILLS OR IN THE PERFORMANCE OF HEALTHCARE OPERATIONS OF **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC** ALONG WITH MY RIGHT WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. I FURTHER UNDERSTAND THAT COPIES OF THE NOTICE OF PRIVACY PRACTICES FOR **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC** ARE AVAILABLE AT THE FRONT DESK.

SIGNED ______________________________________DATE____________________________

CONSENT TO TREAT - FOR SERVICES BEGINNING ______________, I GIVE MY CONSENT FOR TREATMENT OF MYSELF, MY MINOR CHILD OR DEPENDENT TO **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC.** THIS CONSENT TO TREAT WILL REMAIN VALID UNTIL I NOTIFY **SPRINGFIELD PHYSICAL THERAPY & WELLNESS LLC** IN WRITING OTHERWISE.

SIGNED ______________________________________DATE____________________________