PHYSICAL THERAPY RESTORING FUNCTION

PATIENT INFORMATION

Today's Date: _____

Name: _____ SS#_____/_____/_____
First MI Last (Required for Work Comp Only)

○Male ◯Female Date of Birth: _____/_____/_____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address: _____
Street Address City State Zip Code

Email Address: _____ Home: (_____) _____-_____Cell Phone: (_____) _____-_____
Would you like to receive reminders by email? ◯Yes ◯No Would you like to receive reminders via text message? ◯Yes ◯No

Emergency Contact: _____ Ph: (____) _____-_____ Relationship:_____

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Physical Therapy Restoring Function.

Signature: _____ Date: _____ Relationship: _____
(Parent or Guardian must sign if patient is under 18 years of age)

FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all the charges regardless of my existing medical coverage. I hereby give authorization for payment of insurance benefits to be made directly to FOHC, FHN, or IOE for services rendered. In the event that my insurance company forwards payment directly to me, instead of FOHC, FHN, or IOE, I will immediately deliver said payment to FOHC, FHN, or IOE.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for FOHC, FHN, or IOE to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Signature of Person Responsible for Charges: _____Date:_____ Relationship: _____
(Parent or legal guardian must sign if patient is under 18 years of age)

ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand Physical Therapy Restoring Function reserves the right to modify the privacy practices outlined in the notice and I have received or been offered a copy of the Notice of Privacy Practices for Physical Therapy Restoring Function.

Signature: _____Date:_____ Received / Offered (circle one)
(Parent or legal guardian must sign if patient is under 18 years of age)

PRIMARY INSURANCE

Name of Subscriber: _____ Birthdate: _____/_____/_____Relationship to Patient_____

Phone: (_____) _____-_____ SS#_____-_____-_____ Insurance Co: _____

Subscriber #:_____ Group #/Name: _____

SECONDARY INSURANCE ***If you have NO Secondary Coverage Initial Here (_____)

Name of Subscriber: _____ Birthdate: _____/_____/_____ Relationship to Patient_____

Phone: (_____) _____-_____ SS#_____-_____-_____ Insurance Co: _____

Subscriber #:_____ Group #/Name: _____

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

HEIGHT: _____ WEIGHT: _____

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

☐ Injury as a result of a fall in the past year? Date of injury or onset: _____
☐ Two or more falls in the last year?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**