PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home: _____	☐	_____
Work: _____	☐	_____
Cell: _____	☐	_____

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: EN English **Interpreter required?** ☐ Yes

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured: _____

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient **Date**

Premier PT
PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT
I consent to rehabilitation and related services at:
Premier PT
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS
I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**_____

LIABILITY
I know and agree that: Premier PT
is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE
I hereby release, discharge and acquit: Premier PT
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:**_____

AUTHORIZATION OF PAYMENT
I hereby assign all benefits directly to: Premier PT
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:**_____

FINANCIAL POLICY
I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
To assist in establishing your account, please:
- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:**_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS
I acknowledge receipt of Notice of Privacy Practices. **Initials:**_____
I acknowledge receipt of the Statement of Patient Rights. **Initials:**_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

Premier PHYSICAL THERAPY & SPORTS PERFORMANCE

HEALTH HISTORY

Patient Name: _____ Today's Date: _____

Have you ever had these symptoms before (circle): Yes / No - If yes, when: _____

Date of Injury/onset: _____ Do you currently exercise moderately three times per week? Yes No

The following is a list of common health problems. In the first column please indicate if you currently or have ever had any of the problems in the past. In the second column please indicate if you are currently receiving treatment for the problem. In the last, please indicate if the problem currently limits any of your daily activities.

	Do you or have you had the problem?	Do you currently receive treatment for this problem?	Does this problem limit your daily activities?
Smoking/Tobacco Use	Yes No	Yes No	Yes No
Drug or Alcohol Abuse	Yes No	Yes No	Yes No
Anxiety or Depression	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No
Cardiovascular Condition	Yes No	Yes No	Yes No
Cancer	Yes No	Yes No	Yes No
Lung Disease or Asthma	Yes No	Yes No	Yes No
Heart Disease/Heart Attack	Yes No	Yes No	Yes No
High Cholesterol	Yes No	Yes No	Yes No
Pacemaker	Yes No	Yes No	Yes No
High or Low Blood Pressure	Yes No	Yes No	Yes No
Ulcer or Stomach Disease	Yes No	Yes No	Yes No
Nausea or Vomiting	Yes No	Yes No	Yes No
Hernia	Yes No	Yes No	Yes No
Kidney Disease	Yes No	Yes No	Yes No
Liver or Gall Bladder Problems	Yes No	Yes No	Yes No
Bipolar Disorder	Yes No	Yes No	Yes No
Anemia or Blood Condition	Yes No	Yes No	Yes No
Ringing in the Ears	Yes No	Yes No	Yes No
Autism Spectrum Disorder	Yes No	Yes No	Yes No
Sexual Dysfunction	Yes No	Yes No	Yes No

(Please view other side)

Seizures	Yes	No	Yes	No	Yes	No
Headaches	Yes	No	Yes	No	Yes	No
Dizziness, Fainting, or Vertigo	Yes	No	Yes	No	Yes	No
Nerve Disease or Disorder	Yes	No	Yes	No	Yes	No
Muscle Disease or Disorder	Yes	No	Yes	No	Yes	No
Auto Immune Disease	Yes	No	Yes	No	Yes	No
Hearing Loss	Yes	No	Yes	No	Yes	No
Vision Loss	Yes	No	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Yes	No
Allergies	Yes	No	Yes	No	Yes	No
Skin Disorders	Yes	No	Yes	No	Yes	No
Are you Pregnant?	Yes	No	Yes	No	Yes	No
Bowel or Bladder Irregularities	Yes	No	Yes	No	Yes	No
Menstrual Irregularities	Yes	No	Yes	No	Yes	No
Recent Unexplained Weight Gain or Loss	Yes	No	Yes	No	Yes	No
History of Stroke	Yes	No	Yes	No	Yes	No
Osteoporosis/Osteopenia	Yes	No	Yes	No	Yes	No
Numbness or Tingling	Yes	No	Yes	No	Yes	No
Shortness of Breath	Yes	No	Yes	No	Yes	No
History of falls in past 12 months	Yes	No	Yes	No	Yes	No

Surgeries with corresponding dates: _____

_____

Are you currently taking any opioids? Yes No

Current Medications and reasons for taking: _____

_____

Signature: _____ Date: _____

Relationship to patient: _____