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** ___________

Medicare Secondary Payor

As part of our participation in the Medicare program, we are required to ask each of these questions to confirm that Medicare should act .as your primary insurance coverage. Under our agreement with Medicare, we must also reverify the answers to these questions every 90 days or at the start of a new injury.

This form is not required if you are enrolled in a Medicare Advantage Plan.

Patient: ____________________ **DOB:** _______________
Account: 0105102131

Yes No

☐ ☐ 1. Are you receiving Black Lung Benefits?

☐ ☐ 2. Are your services to be paid for by a Governmental Research Program?

☐ ☐ 3. Are you entitled to benefits through the Department of Veteran Affairs?

☐ ☐ 4. Is your therapy related to a non-work accident?

- If so, what date did it occur? ____________________

☐ ☐ 5. Is your therapy related to work injuries or illnesses?

- If so, what date did it occur? _______________
- And the name of the employer? _____________

☐ ☐ 6. Is your therapy related to an injury or illness covered under an automobile or premise (Home or Business) insurance? If YES, what is the name of the Insurance and claim number?
Ins. ___________________________ Claim No. ____________________

☐ ☐ 7. Do you believe that another party is responsible for your injury/Illness? If YES, what is the name of the Insurance and claim number?
Ins. ___________________________ Claim No. ____________________

☐ ☐ 8. Do you have a group health plan insurance based on your own current employment, or the employment of either your spouse or other family member? If YES, how many employees, including yourself or spouse work for the employer from whom you have Group Health Insurance.

☐ **1-19** ☐ **20-99** ☐ **100 or More**

☐ ☐ 9. Are you under 65 AND on Medicare due to DISABILITY and covered by Group Health?

☐ ☐ 10. Are you under 65 and on Medicare for ESRD (end stage renal disease) diagnosis?
If YES, what was the date of your diagnosis? _______________
Have you received maintenance dialysis treatments? ________
If YES, what date did your dialysis begin? _______________
Have you received a Kidney Transplant? _______________
If YES, what was the date of your transplant? ____________

Patient Signature:____ Date:__________________

Patient initials reverification if above signature is >= 90 DAYS _____ 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?	
	Yes	No	Yes	No	Yes	No
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: ____________________

Name:_________________________________ Date of Birth:_______________

- Per Medicare requirements, each patient must provide a complete medicine list of their current medicines including dosage, frequency, and mode of administration.
- Include prescription and non-prescription medications plus any vitamins or supplements you take.

Medication	Dosage	Frequency	Mode of Administration
EXAMPLE: Aspirin	325 mgs	1x/day	By mouth

To the best of my knowledge the above medication list is accurate and up to date.

Signature:_________________________________ Date:_______________