

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?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | <input type="checkbox"/> Marketing Ad - Facebook |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | <input type="checkbox"/> 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 (Dover)
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 (Dover) 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 (Dover) is not responsible for loss or damage to personal valuables. Initials: _____				
WAIVER AND RELEASE I hereby release, discharge and acquit: Premier PT (Dover) 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 (Dover) 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: <ul style="list-style-type: none">- 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: 0105201061 _____

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:** _____



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						
Drug or Alcohol Abuse						
Anxiety or Depression						
Diabetes						
Cardiovascular Condition						
Cancer						
Lung Disease or Asthma						
Heart Disease/Heart Attack						
High Cholesterol						
Pacemaker						
High or Low Blood Pressure						
Ulcer or Stomach Disease						
Nausea or Vomiting						
Hernia						
Kidney Disease						
Liver or Gall Bladder Problems						
Bipolar Disorder						
Anemia or Blood Condition						
Ringing in the Ears						
Autism Spectrum Disorder						
Sexual Dysfunction						

(Please view other side)

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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: _____