Patient Information Form

Patient Information

Patients Name | Nickname | Birthdate | Email Address

Address | City | State | Zip

Home Phone | Cell Phone

Referring Physician | Primary Care Physician | Seeking Therapy For

Emergency Contact's Name | Phone | Relationship to Patient

Insurance Information

Primary Insurance

Policy Holder Name (if other than patient) | Address | Birthdate | Social Security # | Phone

Secondary Insurance

Policy Holder Name (if other than patient) | Address | Birthdate | Social Security # | Phone

Medical History

☐ Male ☐ Female: ☐ Pregnant or Recently Pregnant Marital Status S M D W Legally Separated

Check if you have ever been diagnosed with any of the following:

☐ Arthritis	☐ Heart Problems	☐ Asthma	☐ Stroke
☐ Fractures	☐ Pacemaker	☐ COPD/Lung Problems	☐ Epilepsy
☐ Osteoporosis	☐ Defibrillator	☐ PVD	☐ MS
☐ Metal Implants	☐ Hypertension	☐ Lymphedema	☐ Hepatitis/HIV
☐ Depression	☐ Thyroid	☐ Migraines/Headaches	☐ Cancer
☐ Bipolar	☐ Diabetes	☐ Other: _____	

☐ Recent Surgery/Date _____

Problems with:	☐ Shortness of Breath	☐ Bladder/Bowel Control	☐ Vision
☐ Dizziness	☐ Night Pain	☐ Blood in Urine/Stool	☐ Hearing
☐ Falls	☐ Skin Rash	☐ Weight Loss/Gain	☐ Speech

Allergies: ☐ None ☐ Latex ☐ Cortisone ☐ Bee Stings ☐ Tape ☐ Other: _____

Current Medications, including over the counter: ☐ None ☐ Separate List Provided

List: _____

Are you currently taking Coumadin or other blood thinner? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Are you: ☐ right-handed ☐ Left-handed ☐ Use both easily

Work History

Are you currently working? □ Yes □ No Occupation _____

If Yes: □ Regular duty □ Light duty Employer: _____ Phone #: _____

Last date worked: _____ If off work, return to work date: _____ □ Unknown

Job duties: □ Sitting □ Standing □ Reaching □ Lifting □ Repetitive □ Other: _____

Indicate maximum lifting requirements:

Other Pertinent Information

Have you had any Physical Therapy this year? Yes No If so, how many visits?

Have you had any Chiropractic visits this year? Yes No If so, how many visits?

Are you receiving Home Health Services of any kind at this time? Yes No If yes, please inform receptionist at this time.

Have you received any type of Home Health Services: Yes No If so, when were you discharged (your final visit)?

Regarding Privacy: I have read a copy of DPT's Privacy Policies (sign & date)

Please initial the following that are acceptable to you: DPT staff may leave a message with a person at my home _____
And/or on my voicemail/answering machine at home _____ work _____ Or cell phone _____

DPT can discuss my account or care with the following individuals:

I give my consent for treatment, authorize the release of necessary information to insurance carriers & appropriate personnel, & request that my insurance carriers pay DPT directly. If direct payment is not permitted, I request that payment be issued jointly to DPT & myself and mailed directly to DPT. I will endorse checks so DPT may cash & apply to my account accordingly. I understand I am financially responsible for any and all charges occurred. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.

Patient/Guardian Signature: _____ Date

Defiance Physical Therapy and Sports Medicine

Welcome to our facility! In order to better serve you, we would like you to be aware of the following:

Arrival: Please notify us of your arrival. If we have not called you within 5 minutes, please feel free to inquire about the wait.

Children and Visitors: Our treatment areas are quite small and are not sound proof. All "non-patients" must, if possible, remain in the waiting area during treatment hours.

Appointments: Please schedule all of your appointments at the time of initial evaluation, if possible. Regular attendance is vital to optimal progress in physical therapy. **If you are over 15 minutes late for your appointment, we will start treatment as soon as our schedule allows.** Please try to be prompt. We request 24-hour notice, if possible, when you cancel an appointment. Any cancellation made less than 2 hours before your appointment time may result in a charge for the appointment. Repeated cancellations or not appearing for scheduled appointments may result in a discontinuation letter sent to your referring physician and insurance company. At that point, a new prescription would be required to resume therapy.

Insurance Coverage: If you have any questions regarding your insurance coverage, we will assist you in contacting your insurance company regarding coverage of outpatient physical therapy. We will also bill your insurance companies.

Physician Visits: Please notify us of upcoming visits to your referring physician, at least one week before the date of your appointment so we can re-evaluate you and send a progress note to your physician. This will help him/her decide in the best source of action for your recovery.

Requesting Assistance During Treatment: Each treatment area is equipped with a hand bell to be used to contact the staff if you need assistance for any reason.

Weather Emergencies: In the event of severe weather, the clinic may be closed and/or staff may arrive late. If you are scheduled on such a day, please call to check the status of your appointment.

Please inform your therapist if you feel you are not making progress in therapy. It is imperative that we know this. If you have any questions, please feel free to ask us. We will help you in any way possible.

I have read and understand the above.

_____ _____

Signature Date