Columbus Physical Therapy, PC

THE FEEL GOOD EXPERIENCE

Columbus Physical Therapy Humphrey Physical Therapy Northeast Nebraska Physical Therapy

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Name: _____
Last First Middle

Patient Address:

_____
Street/P.O. Box City State Zip

Social Security #: _____ Gender: M F Date of Birth: _____ Marital Status: M S

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer: _____

Circle Best method of contact: Home Cell Work Email Best time to reach: _____

Circle Preferred Appointment Reminder Method: Call Text Message Email

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Circle Spouse / Parent Name: _____ SS#: _____

Date of Birth: _____ Phone: _____ Employer: _____

Person to notify in case of emergency OUTSIDE of household:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip

Why Did You Choose Our Clinic? Please Place an "X" In The Box That Most Applies.							
PHYSICIAN	FRIEND	WORKSHOP	INTERNET	RADIO	MAIL/ NEWSLETTER	LOCATION	"I AM A PAST PATIENT"

Did your physician recommend physical therapy? ☐ Yes ☐ No

Did your physician tell you to come to Columbus Physical Therapy, P.C.? ☐ Yes ☐ No

Referring Doctor: _____ ***Next Doctor Appointment:*** _____

Medical History

_____.

Have you received **ANY** physical therapy in this current calendar year? ☐ Yes ☐ No

If yes, where? _____ *When?* _____

Was it for the same condition? ☐ Yes ☐ No *If not, please specify*:

_____

_____

Date of injury or onset of current episode of symptoms/illness:_____

Have you seen a physician for this condition? ☐ Yes ☐ No *if yes, when?* _____

Height:_____ Current weight:_____ Do you have a pacemaker? ☐ Yes ☐ No

Have you experienced a fall in the past year? ☐ Yes ☐ No *If yes, were you injured in the fall?* _____

_____

What kind of pain are you having? *Please an X in the box/boxes below:*

Aching	Numbness	Pins & Needles	Burning	Stabbing

If you are having pain, is there anything that makes it feel better or worse? *Briefly explain:*_____

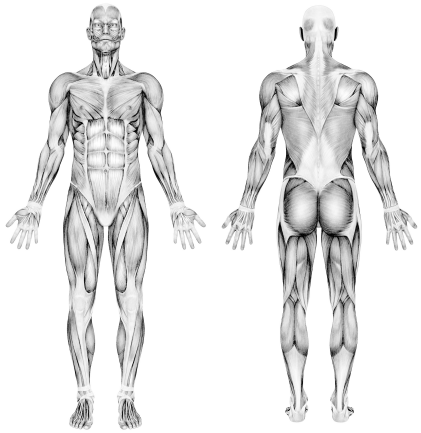
_____

Place injury occurred: ☐ Home ☐ School ☐ Work ☐ Auto ☐ Other:_____

How bad is your pain? *Please circle the number below:*

Low Pain			Moderate Pain				Maximal Pain		
1	2	3	4	5	6	7	8	9	10

Please mark the areas of pain on the diagram below:



Please provide a list of your current medications.

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Responsibility Information

Who will be primarily responsible for the bill? _____

I will be paying my share of financial responsibility by: ☐ Cash ☐ Check ☐ Credit Card

PRIMARY Insurance Company: _____Phone #: _____

Policy Holder's Name:

_____

Last First Middle

Policy Holder's Social Security #:_____ Date of Birth: _____

Policy Holder's Address: Policy Holder's Phone #:_____

_____

Street

City State Zip

Policy Holder's Employer: _____Position: _____

Is there Secondary Insurance? ☐ Yes ☐ No

If Yes, Name of the Secondary Insurance Company: _____

IS THIS A WORKER'S COMPENSATION CLAIM? ☐ Yes ☐ No

Date of Injury: _____ Employer at Time of Injury: _____

Insurance Company: _____Address: _____

Phone Number: _____ Claim #: _____Contact Person: _____

IS THIS AN ACCIDENT CASE? ☐ Yes ☐ No ☐ VEHICLE ☐ OTHER: _____

Insurance Company to Bill: _____

Address:_____

Street City State Zip

Phone #: _____Claim #:_____

Adjuster Name: _____ Date of Accident: _____

Is there an attorney involved in your case? ☐ Yes ☐ No

Attorney's Name: _____ Phone: _____

Address:_____

Street City State Zip

I hereby authorize Columbus Physical Therapy, P.C. to furnish information to the insurance carriers concerning my

I hereby authorize Columbus Physical Therapy, P.C. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance within 30 days of initial statement.

I understand that by signing I am giving my permission for treatment. I hereby authorize my referring physician to release any records necessary to secure payment of benefits to Columbus Physical Therapy, P.C.

I also authorize Columbus Physical Therapy, P.C. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ **DATE:** _____

Parent Signature for Minor (under 18 years of age): _____

Printed Parent Name: _____ DATE: _____

I have been provided with a brochure required by the Health Insurance Portability and Accountability Act (HIPAA) from Columbus Physical Therapy, P.C. This document explains how medical information about me may be used, disclosed and/or accessed.

_____ _____

Signature **Date**

Office Use Only	
ITF:	PT:
Case