

NORTH HILL PHYSICAL THERAPY, INC.

Patient Information Sheet

LAST NAME _____ M.I. _____

FIRST NAME _____ DOB ____ - ____ - ____

MARITAL STATUS: S M D W SS# ____ - ____ - ____

MAILING ADDRESS _____

CITY _____ ZIP _____

HOME PHONE #() ____ - ____

EMPLOYER _____

WORK PHONE #() ____ - ____

REFERRING PHYSICIAN _____

PHYSICIANS PHONE #() ____ - ____

ATTORNEY (if applicable) _____

ATTORNEY PHONE #() ____ - ____

HOW DID YOU LEARN ABOUT OUR OFFICE?

Your Doctor's Office Family/Friend Mailer
Newspaper Phone Book Billboard

CONFIDENTIALITY NOTICE: I understand that all information regarding my care is privileged confidential information. I give my consent to release my records for the purpose of continuation of care and/or billing purposes.

CONSENT TO CARE: I hereby give my consent to receive treatment as a patient at North Hill Physical Therapy, Inc.

AUTHORIZATION OF TREATMENT OF A MINOR: I authorize North Hill Physical Therapy, Inc. to treat the minor patient named above.

Signed _____ Date _____

Patient Insurance Information

Primary Insurance: _____

Group #: _____ ID#: _____

Address: _____ Phone: _____

Subscriber's Name: _____

Patient's Relationship to Subscriber: _____

Subscriber's Date of Birth: _____ - _____ - _____

Subscriber's Social Security #: _____ - _____ - _____

Subscriber's Employer: _____

Secondary Insurance: _____

Group #: _____ ID#: _____

Address: _____ Phone: _____

Subscriber's Name: _____

Patient's Relationship to Subscriber: _____

Subscriber's Date of Birth: _____ - _____ - _____

Subscriber's Social Security #: _____ - _____ - _____

Subscriber's Employer: _____

Financial Agreement: I understand that I am financially responsible for any balance due. I authorize my insurance benefits to be paid directly to North Hill Physical Therapy, Inc. I also understand that I will be charged a service charge of 1% per month on any amount outstanding 60 days past due.

Financial Responsibility of a Minor: It is the policy of North Hill Physical Therapy, Inc. that the parent or guardian who requests medical treatment of a minor is financially responsible for services rendered.

Signed: _____ Date: _____

Physical Therapy Patient Questionnaire

Name: _____ Date: _____

Is this the result of an injury? Yes No

Date of injury: _____ Where were you? _____

Please briefly describe your injury or condition:

Does your injury prevent you from working? Yes No

If yes, what was the last day you worked?: _____

Have you had any special tests? (Check all that apply)

MRI CT-SCAN EMG X-RAY Bone Scan Other:

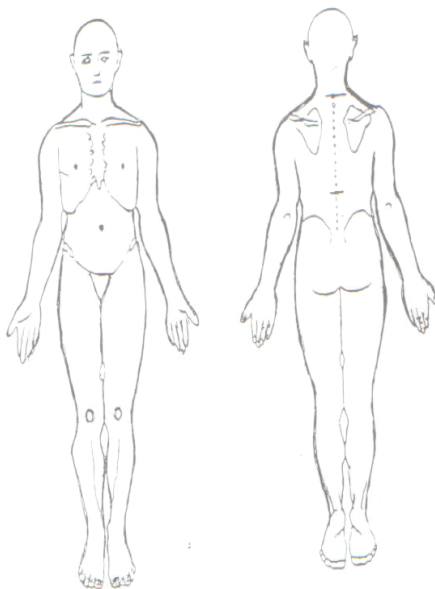
Rate your pain on a scale of 0-10: _____ (0 is none, 10 is severe)

What time of day is your pain the worst? _____

Do you have any numbness? _____

Are you able to sleep comfortably through the night? _____

Shade the area of pain:



Physical Therapy Patient Questionnaire (continued)

Have you had any recent weight loss or gain?

Current Medical Conditions:

HIV/AIDS Hepatitis Diabetes Cancer

Seizures Asthma Pregnant

Broken Bones Metal Pins Blood Clots

High Blood Pressure Heart Condition

Other: _____

List all medications you are currently taking:

Do you smoke? Yes No If yes, how much? _____

What are your goals for Physical Therapy? (please check one or more)

Pain relief Improved strength Improved flexibility

Learn proper exercise Learn proper body mechanics

Improved endurance Return to work Return to sports

Patient Signature: _____ Date: _____

Additional info:

Safety policy

For the safety of all patients and children we request that all children under the age of 6 years old be supervised by a non-patient adult in the waiting area.

Attendance Policy

Successful rehabilitation requires consistent in treatment. Keeping your appointments as prescribed allows us to progress your treatment as rapidly as possible and reflects your commitment to the rehabilitation process. We do understand that emergencies and unforeseen circumstances can arise. However, if you know in advance that you will be late or unable to attend that day's appointment we would appreciate a phone call.

Privacy Policy

Your privacy is very important to us. We will only authorize to release information to you, your Doctor and your Insurance co.. only. Our privacy policy can be obtained upon request.

I have read and understand/agree to the above statement.

Signature _____ Date _____