WHITE ROSE PHYSICAL THERAPY – PATIENT INFORMATION FORM

Name: ______________________ Home Phone: ______________ Date: ____________

Home Address: ______________________________ City: ______________ Zip: ________

Social Security Number: __________________ Birth Date: __________ Cell phone #: __________

Full-time student____ Part-time student ____ Single____ Married ____ Other____

Employer: ________________________ Occupation: __________ Work Phone: __________

Employer Address: __________________________ City: ______________ Zip:________

Spouse's Name: __________________________ Social Security Number: ______________

Spouse's Employer: ____________________ Occupation: __________ Work Phone: __________

Spouse's Employer Address: ______________________________ Spouse's Birth Date__________

Insured's Address: ______________________________ Insured's Phone: ______________

Insured's Employer: __________________________ Insured's Birth Date: ______________

Referring Physician: __________________________ Family physician: ________________

INSURANCE INFORMATION

Is your condition related to:			
	car accident?	Yes _______	No _______
	workers' compensation?	Yes _______	No _______
	other?	Yes _______	No _______

Date of accident: ______________ To whom did you report injury? ________________________

To whom should we send bills? (Please include claim #, adjuster's name, address and phone #

____

____

Do you have an attorney? Yes _____ No _____ Information: ______________________________

Insurance Company:__________________ Contract #: ______________ Group #: ____________

Second insurance? Yes ____ No ____ Second Insurance Company: ________________________

How will you be paying for the physical therapy services? Cash / Check MasterCard / Visa

When do you return to the referring physician? ________________

I agree to be treated by White Rose Physical Therapy and understand White Rose PT will bill my primary insurance carrier for all treatments. I assign payment directly to White Rose Physical Therapy for all insurance benefits otherwise payable to me for services rendered. It is my responsibility to ensure that my bill is paid by my insurance carrier within a reasonable time (ninety days from the date of service) and I will help facilitate payment of claims by contacting my insurance company when necessary. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information.

____

Signature of Patient or Responsible Party

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will bill your primary insurance every three to six (3-6) visits. Payment of any co-insurance, co-pays and deductibles are due at the time of treatment, unless other payment arrangements have been made in advance with our staff. We accept cash, checks, Visa and MasterCard. For those without insurance, payment for services is due at the time of treatment, unless other payment arrangements have been made.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of “UCR”. “UCR” is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most insurance companies.

   This statement does not apply to companies who reimburse based on an arbitrary “schedule” of fees, which bears no relationship to the current standard and cost in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We realize that once in a while, circumstances require you to cancel or miss appointments. We are happy to reschedule your appointment when this is necessary. While canceling appointments can create scheduling problems, it also interrupts your rehabilitation program. Frequent cancellations and no-shows make our treatments less effective toward reaching your goals and the goals of your referring physician. Please attend all treatments, if possible, so that together we can reach your full potential and maximum recovery.

As a courtesy to our staff and patients, and in order to better serve <u>all</u> of our patients, <u>please call us at least 24 hours in advance with your cancellation</u>. Without proper notification, a fee of $40 will be charged for the missed appointment (which is <u>not</u> billable to insurance). In the event you do not cancel and fail to show up for three consecutive appointments, all future appointments will be removed and rescheduling will be required. If you are late for an appointment, we will attempt to reschedule without inconveniencing other scheduled patients.

I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for all professional services rendered. I have read all of the information on both sides of this form, and certify that this information is correct to the best of my knowledge.

______________________________	______________________________	____________
PLEASE PRINT NAME	PATIENT’S SIGNATURE	DATE

WHITE ROSE PHYSICAL THERAPY- HEALTH HISTORY FORM

1. **Name:**

   ____
   Last

   ____
   First MI Jr/Sr

2. **With whom do you live?**
   - ❑ Alone
   - ❑ Spouse only
   - ❑ Spouse and other(s)
   - ❑ Child (not spouse)
   - ❑ Other relative (s) (not spouse or children)
   - ❑ Group setting
   - ❑ Personal care attendant
   - ❑ Other

3. **Employment/Work (Job/School/Play)**
   - ❑ Working full-time outside home
   - ❑ Working full-time from home
   - ❑ Working part-time outside home
   - ❑ Working part-time from home
   - ❑ Homemaker
   - ❑ Student
   - ❑ Retired
   - ❑ Unemployed

4. **SOCIAL/HEALTH HABITS**

   Smoking

   a. Currently smoke tobacco? ❑Yes ❑No
      - ❑ Cigarettes # packs per day___
      - ❑ Cigars/Pipes # per day___

   b. Smoked in past?
      - ❑ Yes/ Year quit: ______ ❑ No

   Alcohol

   a. How many days/ week do you drink beer, wine, or other alcoholic beverages, on average? _____

   b. If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ________

5. **FAMILY HISTORY** (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/father, and age of onset if known.)

   a. Heart Disease________________________
   b. Hypertension________________________
   c. Stroke______________________________
   d. Diabetes____________________________
   e. Cancer______________________________
   f. Psychological________________________
   g. Arthritis____________________________
   h. Osteoporosis_________________________
   i. Other______________________________

6. **MEDICAL/SURGICAL HISTORY**

   a. Please check if you have ever had:

   ❑Arthritis
   ❑Broken bones/fractures
   ❑Osteoporosis
   ❑Blood disorders
   ❑Circulation/vascular problems
   ❑Heart problems
   ❑High blood pressure
   ❑Lung problems
   ❑Stroke
   ❑Diabetes/ high blood sugar
   ❑Hypoglycemia/ low blood sugar
   ❑Head injury
   ❑Depression
   ❑Multiple sclerosis
   ❑Muscular dystrophy
   ❑Parkinson disease
   ❑Seizures/epilepsy
   ❑Developmental or growth problems
   ❑Allergies
   ❑Thyroid problems
   ❑Cancer
   ❑Kidney problems
   ❑Infectious disease (eg,,tuberculosis; hepatitis)
   ❑Ulcer/stomach problems
   ❑Repeated infections
   ❑Skin diseases
   ❑Other: ________________________________

   b. Within the past year, have you had any of the following symptoms? (Check all that apply.)

   ❑Chest pain
   ❑Heart palpitations
   ❑Cough
   ❑Hoarseness
   ❑Shortness of breath
   ❑Dizziness or blackouts
   ❑Coordination problems
   ❑Weakness in arms/ legs
   ❑Loss of balance
   ❑Difficulty walking
   ❑Joint pain or swelling
   ❑Pain at night
   ❑Difficulty sleeping
   ❑Loss of appetite
   ❑Nausea/vomiting
   ❑Difficulty swallowing
   ❑Bowel problems
   ❑Weight loss/gain
   ❑Urinary problems
   ❑Fever/chills/sweats
   ❑Headaches
   ❑Hearing problems
   ❑Vision problems
   ❑Other:___________

   c. Have you ever had surgery? ❑Yes ❑No

   If yes, please describe, and include dates:

   ____________________________ _______________
   ____________________________ _______________
   ____________________________ _______________
   month year

   For men only: Have you been diagnosed with prostate disease? ❑**Yes** ❑**No**

   For women only: (Check all that apply)

	Yes	No
a. Pelvic inflammatory disease	❑	❑
b. Endometriosis	❑	❑
c. Trouble with your period	❑	❑
d. Complicated pregnancies or deliveries	❑	❑
e. Pregnant, or think you might be	❑	❑
f. Other gynecological or obstetrical difficulties	❑	❑

   If yes, please describe__________________________

7. **CURRENT CONDITION(S)/ CHIEF COMPLAINT(S)**

a. Describe the problem(s) for which you seek Physical therapy____________________________

____

b. When did the problem(s) begin? _______________
month year

c. Have you ever had the problem(s) before? ❑**Yes** ❑**No**

If Yes: 1. What did you do for the problem?
____

2. Did the problem(s) get better? ❑**Yes** ❑**No**

3. About how long did the problem(s) last?
____

d. What are you goals for physical therapy?
____

e. Are seeing anyone else for the problem(s)?

- ❑Acupuncturist
- ❑Cardiologist
- ❑Chiropractor
- ❑Dentist
- ❑Family Practitioner
- ❑Internist
- ❑Massage therapist
- ❑Neurologist
- ❑Obstetrician/ gynecologist
- ❑Occupational therapist
- ❑Orthopedist
- ❑Osteopath
- ❑Pediatrician
- ❑Podiatrist
- ❑Primary care phys.
- ❑Rheumatologist
- Other__________________
____

8. **FUNCTIONAL STATUS/ACTIVITY LEVEL**

a. Difficulty with locomotion/movement:
- ❑Bed mobility
- ❑Transfers (such as moving from bed to chair, bed to commode)
- ❑Gait (walking)
  - ❑on level terrain
  - ❑on stairs
  - ❑on ramps
  - ❑on uneven terrain

b. Difficulty with self-care:
- ❑Bathing
- ❑Dressing
- ❑Eating
- ❑Toileting

c. Difficulty with home management:
- ❑Household chores
- ❑Shopping
- ❑Driving/transportation
- ❑Care of dependents

d. Difficulty with community & work activities
- ❑Work/school
- ❑Recreation or play activity

9. **MEDICATIONS**

a. Do you take any prescription medications?
❑**No** ❑**Yes**, please list:________________________

____

b. Do you take any nonprescription medications?
- ❑Advil/Aleve
- ❑Antacids
- ❑Ibuprofen/Naproxen
- ❑Antihistamines
- ❑Aspirin
- ❑Decongestants
- ❑Herbal supplements
- ❑Tylenol
- ❑Other:__________________________________
____

c. Have you taken any medication previously for the Condition for which you are seeing the physical Therapist?
❑**No** ❑**Yes**, please list:________________________

____

10. **OTHER CLINICAL TESTS**-within the past year have you had any of the following tests?

- ❑Angiogram
- ❑Arthroscopy
- ❑Biopsy
- ❑Blood tests
- ❑Bone scan
- ❑Bronchoscopy
- ❑CT scan
- ❑Doppler ultrasound
- ❑Echocardiogram
- ❑EEG(electroencephalogram)
- ❑EKG (electrocardiogram)
- ❑EMG (electromyogram)
- ❑Mammogram
- ❑MRI
- ❑Myelogram
- ❑NCV (nerve conduction velocity)
- ❑Pap smear
- ❑Pulmonary function test
- ❑Spinal tap
- ❑Stool tests
- ❑Stress test (eg, treadmill, bicycle)
- ❑Urine tests
- ❑X-rays
- ❑Other:_____________________