



# **ORTHOPEDIC & SPINE PHYSICAL THERAPY**

## **NEW PATIENT FORM**

## PRINT CLEARLY

Name (First)	(Last) City Work Phone			(MI)	
Address			State Zip		
Home Phone					
Birth Date	Age	Sex: M/F			
Email Address		Marital S	Status: M S D W		
Emergency Contact		Tele	phone		
Referring Physician	n Primary Physician				
Who may we thank for	your referral? _				
Injury Type: Work	Auto Home	Other	I	njury Date	
Primary Insurance		ID#		Group #	
Insured Name		DOB			
Secondary Insurance _		ID#		Group #	
Insured Name		DOB			
Please Read and Sign:					
for any services furnish needed to determine t	ed to me by the he benefits payo	clinician. I authorble for related se	orize my holder of ervices about me b		
Signature:			Date:		
I am aware that paymalso be responsible for				es are rendered. I may yment is made.	
Signature:			Date:		
	harged a <u>\$30.00</u>	FEE per follow-up	o, and a <u>\$50.00 FEE</u>	of my scheduled for initial evaluations. If I the rest of my scheduled	
Signature:			Date:		

# Orthopedic & Spine PT Medical Screening Form

Pregnant: Y N						
Postures / Stresses		Leisure / Hobbies				
Exercise Routine_		Pacemaker Y / N				
X-ray, MRI, or other	er imaging study? Y / N V	Vhat Body Part(s)	<del></del>			
<b>Medications:</b> Nil / N	ISAIDS / Analgesics / Ster	oids / Anticoagulants / Injections /	Other			
Recent/major surge	ry: Y / N	Accidents: Y / N				
Past Medical Histor	y: Please circle each cond	<u>lition that you have been told yo</u>	u have (or had).			
Cancer	Diabetes	Kidney Disease	Liver Disease			
High Blood Pressure	Heart Disease	Angina/Chest Pain	Bone or Joint Infection			
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease			
Blood Clots	Ulcers	Asthma/Lung Disease	Fibromyalgia			
Stroke						
Are you allergic to la	ntex? YES NO Other A	Allergies:				
Currently I am experiments  Fever/chills/sweats Changes in appetite Dizziness Nausea /Vomiting	Poor balance (falls) Difficulty swallowing Headaches Increased pain at night	Unexplained weight loss	Numbness or Tingling Shortness of breath nction			
CURRENT SYMPT						
			Present Since:			
	radual / sudden / Injury	1 6 6 6				
	ptoms:		:			
-	odes? 0 1-5 6-10 11+					
Previous Trea	tments/Response to treat	ments:				
Worse with?	Bending / sitting / lying / t	urning/twisting Better with? Bend	ding / sitting / lying / twisting			
Worse? am / a	as the day progresses / pm	Better? am / as the day pro	ogresses / pm			
	etter when you are: Still	• •	cures: belly / back / side R / L Do			
-	with: coughing / sneezin	•	·			

## On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours: 2 No Pain 0 3 5 6 7 10 Worst Pain Best for the last 48 hours: No Pain 0 2 3 4 5 6 7 8 9 1 10 Worst Pain Worst for the last 48 hours: 2 3 5 7 8 10 Worst Pain No Pain 0

Please label on the body charts where your symptoms are and the type of symptom by using the key below.

<u>Ache</u> – ///////// A

Burning -xxxxxxxxB

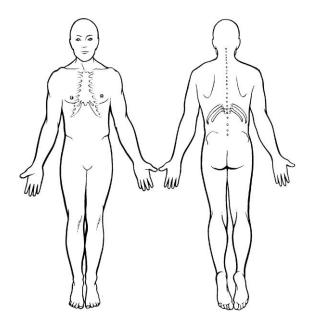
Pins and Needles -^^^^ P

Sharp – ZZZZZ -SH

**Shooting - >>>>>** S

Numbness -IIIIII -N

Indicate if those symptoms are constant or intermittent.



#### 1. Patient Consent to Treat:

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated and which are deemed necessary or advisable by the provider during treatment.

#### 2. Patient Consent for Use and Disclosure of Protected Health Information ("PHI"):

I, the undersigned patient, give my consent to Orthopedic & Spine PT to use or disclose my protected health information ("PHI") to carry out treatment, payment or health care operations. Orthopedic & Spine PT can release, use or disclose my PHI to other health care personnel including, but not limited to, physicians, nurse practitioners, physician assistants, physical therapists, X-ray personnel, students in each of the above disciplines and other such entities or persons are deemed related to treatment, payment and health care operations, as determined in the sole discretion of the provider, his/her practice group and their respective agents.

#### 3. Permission to Release Medical Recorders to Providers:

If another provider who is involved with treatment, payment or health care operations relating to me requests my medical records I consent to the release of my entire medical record maintained by the provider to those other providers.

#### 4. Permission to Release Billing Information Over the Telephone:

I agree, as part of this consent for payment operations, that Orthopedic & Spine PT can disclose billing information to any identity of the calling person and the calling person provides my correct social security number or health plan number.

#### 5. Permission to Call and Leave Voicemail Messages:

I agree that Orthopedic & Spine PT may call and leave a voicemail message at my home or other number I provide them regarding medical appointments, billing or payment issue, or other information related to treatment, payment, or health care operations.

#### 6. <u>Permission to Discuss Protected Health Information with Third Persons:</u>

I agree that the provider may discuss my PHI with any persons that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to the disclosure of my PHI to that person. I also agree that the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional or spiritual care, including, but not limiting to family, friends, clergy and patient advocates. I also agree that the provider, his/her practice group and their agents may disclose my PHI to employers who arrange pay, directly or indirectly, for my medical treatment.

#### 7. Permission to Discuss Protected Health Information Regarding Minors:

I agree that Orthopedic & Spine PT may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI and that I have no right to receive this information.

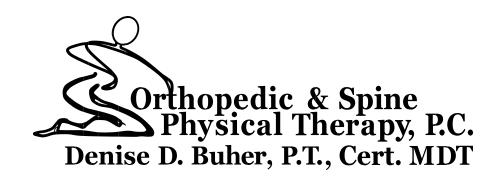
#### 8. Permission to Discuss Protected Health Information with Public Agencies:

I agree that Orthopedic & Spine PT, upon request by the following entities, disclose my PHI to public health agencies, law enforcement and the FDA.

#### 9. Notice of Privacy Practices:

I am aware that I can request "Notice of Privacy Practices" which sets for this provider's privacy practices and my right regarding privacy of my PHI upon request.

Patient Signature	Date
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NAM	E REFERRING MD
	Please indicate the <u>primary</u> reason you chose to come to Orthopedic & Spine PT
	(Please check all that apply)
	My doctor specifically recommended Orthopedic & Spine PT
	MD Name
	I chose Orthopedic & Spine PT from a list my MD Provided me
	I am a previous Orthopedic & Spine PT patient
	A family member, friend or co-worker recommended Orthopedic & Spine PT Name(s)
	My case manager recommended Orthopedic & Spine PT
	My home therapist recommended Orthopedic & Spine PT
	Listed on my Insurance Website/Provider Directory
	Online search led me to Orthopedic & Spine PT Social
	Media Channels: Facebook, Twitter, etc.