CAROLINA PHYSICAL THERAPY & SPORTS MEDICINE, INC. PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

Phone Numbers: **OK To Call** **Best Time To Call**

Home: _____ ☐ _____

Work: _____ ☐ _____

Cell: _____ ☐ _____

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: _____ **Interpreter required?** ☐ Yes

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient **Date**

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
CAROLINA PHYSICAL THERAPY & SPORTS MEDICINE, INC.
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
Initials: _____

LIABILITY

I know and agree that: CAROLINA PHYSICAL THERAPY & SPORTS MEDICINE, INC. is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: CAROLINA PHYSICAL THERAPY & SPORTS MEDICINE, INC. its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: CAROLINA PHYSICAL THERAPY & SPORTS MEDICINE, INC.. I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.
Initials: _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Witness Signature _____

CAROLINA PHYSICAL THERAPY

PATIENT NAME: _____ **TODAY'S DATE:** _____
REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____
PRIMARY CARE PHYSICIAN'S NAME: _____ **ARE YOU PRESENTLY WORKING?** YES NO
CAUSE OF INJURY OR ONSET: _____ **DATE OF NEXT MD APPT:** _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO **IF YES, WHERE:** _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO **IF YES, HOW MANY TIMES:** _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, **IF YES, HOW MUCH?** _____ **WEAR GLASSES / CONTACTS?:** YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO **IF YES, WHEN**_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____
_____

ALLERGIES: Medication _____**Reaction**_____ **Other** _____**Reaction**_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO **If yes what is the Reaction**_____
Are you Allergic to Dexamethasone? YES NO **If yes what is the Reaction**_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (CIRCLE all that apply)

- ☐ Abnormal Bleeding
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ Blood Thinners (Anticoagulants)
- ☐ Bowel Incontinence
- ☐ Cancer
- ☐ Cellulitis
- ☐ COPD
- ☐ Currently Pregnant
- ☐ CVA (Stroke)
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ DVT
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis/HIV
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ Kidney Problems
- ☐ Lymphedema
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
  - *Holter Monitor: Currently wearing?*
- ☐ Psoriatic Arthritis
- ☐ PVD
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sleeping Disorders
- ☐ TB
- ☐ Thyroid Problems
- ☐ Urinary Incontinence

If circled any above, explain: _____

☐ **ANY OTHER MEDICAL PROBLEMS:** _____

SIGNATURE OF PATIENT: _____ **REVIEWED BY Therapist:** _____**Date**_____