

NEW PATIENT INFORMATION FORM

Acct# _____

Date of Call _____ Intake Initials _____ Verifying Initials _____

Physical Therapist _____ Appt. date/time _____

Patient Name _____ Home # _____ Cell # _____

Address _____ City _____ State/Zip _____

E-mail _____ DOB _____ SS# _____ Sex M__F__

Referring MD _____ Rx Date _____ Diagnosis _____

Have you had PT/OT this year? _____ If Answered Yes, Where? _____

Have you had a home health aid or Nurse helping you at home? Yes or No _____ How Long? _____ Agency _____

Primary Insurance Info. WC MVA DOA _____ GROUP HEALTH POS PPO HMO Other _____

Name of Insurance Company _____ ID# _____ Group# _____

Phone # _____ Fax # _____ Effective Date _____

Address _____ City _____ State/Zip _____

Policyholder Name _____ Relation _____ DOB _____ SS# _____

Call Date & Time _____ Rep's Name _____ Call Ref.# _____

In Network Benefits

Out of Network Benefits

% Covered _____ Copay (or%) _____

% Covered _____ Copay (or%) _____

Deductible Amt. _____ Amount Met _____

Deductible Amt. _____ Amount Met _____

Out of Pocket _____ Amount Met _____

Out of Pocket _____ Amount Met _____

Precert? _____ PCP Referral _____

Precert Required _____ PCP Referral _____

of Visits/Days Allowed(specify) _____

#of Visits/days allowed(specify) _____

Dollar Amount Allowed _____

Dollar Amount Allowed _____

Are PT benefits combined with any other benefits? Y or N

Are PT benefits combined with any other benefits? Y or N

If yes what? _____

If yes what? _____

Secondary Insurance Info. WC MVA DOA _____ GROUP HEALTH POS PPO HMO Other _____

Name of Insurance Company _____ ID# _____ Group# _____

Phone # _____ Fax # _____ Effective Date _____

Address _____ City _____ State/Zip _____

Policyholder Name _____ Relation _____ DOB _____ SS# _____

Call Date & Time _____ Rep's Name _____ Call Ref.# _____

In Network Benefits

Out of Network Benefits

% Covered _____ Copay (or%) _____

% Covered _____ Copay (or%) _____

Deductible Amt. _____ Amount Met _____

Deductible Amt. _____ Amount Met _____

Out of Pocket _____ Amount Met _____

Out of Pocket _____ Amount Met _____

Precert Required _____ PCP Referral _____

Precert Required _____ PCP Referral _____

of Visits/Days Allowed(specify) _____

of Visits/days allowed(specify) _____

Dollar Amount Allowed _____

Dollar Amount Allowed _____

Are PT benefits combined with any other benefits? Y or N

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If yes what? _____

If yes what? _____

Additional Info: _____



**MEDICAL HISTORY
PATIENT QUESTIONNAIRE**

Please read and answer the following question. Do you now or have you ever had any of the following?

Patients name: _____
Please print

	<u>YES</u>	<u>NO</u>
Diabetes.....	___	___
High Blood Pressure.....	___	___
Low Blood Pressure.....	___	___
Heart Disease.....	___	___
Stroke.....	___	___
Visual or Hearing Problems.....	___	___
Cancer or Tumors.....	___	___
Coronary artery disease.....	___	___
Congestive Heart Failure.....	___	___
Angina.....	___	___
Aneurysms.....	___	___
Anemia.....	___	___
Seizures or Nervous Disorder.....	___	___
Joint replacement or an Implant.....	___	___
Peripheral Vascular Disease.....	___	___
Persistent Swelling.....	___	___
Shortness of Breath.....	___	___
Asthma of any kind.....	___	___
Bronchitis.....	___	___
Emphysema.....	___	___
Ulcers.....	___	___
Episodes of dizziness or fainting.....	___	___
Difficulty Swallowing.....	___	___
Difficulty with urination of any kind.....	___	___
Arthritis.....	___	___
Bursitis or tendinitis.....	___	___
Unusual or frequent headaches.....	___	___
Bone or Joint problems.....	___	___
Low Back Pain.....	___	___
Multiple Sclerosis.....	___	___
Parkinson's Disease.....	___	___
Lymes Disease.....	___	___
Seizure Disorder.....	___	___
Hernia.....	___	___
Problems with Menstruation.....	___	___
Are you pregnant.....	___	___

Please list any medications you are currently taking:

Please List and date any prior hospitalizations:

Please let us know what your personal goals are with therapy:

Signature: _____

Date: _____

