PT and Sports Rehab
of the Highland Lakes

Patient Demographic Form

Date: _____

PATIENT INFORMATION

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number** **Gender ( )Male ( )Female**

Marital Status ( ) Married ( )Single ( )Divorced ( )Life Partner ( )Separated ( )Widowed ( )Other **Language other than English**

Race ( )Black - Non Hispanic ( )American Indian/ Alaskan Native ( )Hispanic ( )Asian/Pacific Islander ( )White - Non Hispanic ( )other

Home Address **Apt #** **City** **State** **Zip Code**

Home phone **Work Phone** **Other Phone**

Email Address **Employment Status**

Employer **Employer Phone**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ( )Self (if self, skip to Emergency/next of Kin) ( )Spouse ( )Parent ( )Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home phone **Work Phone** **Other Phone**

Email Address **Employment Status**

Employer **Employer Phone**

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Home Address **Apt #** **City** **State** **Zip Code**

Home phone **Work Phone** **Other Phone**

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name **First Name** **Relationship to the Patient**

Home Address **Apt #** **City** **State** **Zip Code**

Home phone **Work Phone** **Other Phone**

How did you hear about us? _____

Date: _____

Patient Medical History and Health Risk Profile

Patient Name: _____

Age: _____ Height:_____ Weight: _____ Gender: ( )Male ( )Female

1.) Problems being treated today

_____

Have you had treatment for this problem before? ( ) yes ( )no When: _____

Please describe the type of treatment: _____

Have you had surgery associated with this problem? ( ) yes ( ) no

If so, please list date and type _____

2.) Do you have any other condition that is aggravated by exercise? _____

3.) Please list names of any primary care physician/internist/cardiologist that you are seeing, or have seen in the past:

Name: _____ Name: _____

Phone: _____ Phone: _____

4.) Are you currently pregnant? ( ) yes ( ) no

5.) Do you need assistance with any of the following?

Transportation	yes	no	Meals	yes	no
Shopping/Errands	yes	no	Personal Care	yes	no
Domestic Chores	yes	no	Other: _____	yes	no

6.) Has your illness/disability caused any of the following?

Financial Problems	yes	no	Family Problems	yes	no
Emotional Problems	yes	no	Other: _____	yes	no

7.) Do you have or have you had any of the following?

Feel faint or dizzy	yes	no	Osteoporosis	yes	no
Frequent pain in heart or chest	yes	no	Known heart disease	yes	no
Pacemaker	yes	no	Diabetes	yes	no
Headaches	yes	no	Swollen ankles	yes	no
Nervous disorders	yes	no	Kidney problems	yes	no
Allergies	yes	no	Heat Sensitivity	yes	no
Seizures	yes	no	Hernia	yes	no
Balance problems	yes	no	Metal implants	yes	no
Hearing problems	yes	no	Vision problems	yes	no
High cholesterol	yes	no	High blood pressure	yes	no
Cancer	yes	no	Low blood pressure	yes	no
Tuberculosis	yes	no	Hepatitis	yes	no

8.) Please circle the closest answer or leave item blank if you do not know:

Cigarettes (per day)	Never	1-5	10-20	30-40	>50
Alcoholic drinks (per week)	Never	1-5	10-20	>20	
Cardiovascular Fitness (per week)	None	Occasional/Recreational		3+ days/week for at least 15 min.	

9.) Respiratory Status: Normal Moderate Severe (shortness of breath with mild exertion)

List of Medications

NAME	(mg)	Amount per day

Please continue on back side if needed….

For returning patients only: There are no changes in Med History _____

Signature Date

PT and Sports Rehab

of the Highland Lakes

Name:_____ **ID #**_____

DOB: _____

CONSENT TO TREATMENT: I voluntarily request PT & Sports Rehab of the Highland Lakes, Inc. to render care, service, treatment, and supervision of services to me. I consent to authorize PT & Sports Rehab of the Highland Lakes. Inc. personnel to perform such care and treatment as ordered or deemed advisable or necessary by my physician(s).

AUTHORIZATION TO RELEASE INFORMATION: I authorize release of all records required by PT & Sports Rehab of the Highland Lakes, Inc., to render care, service, and treatment to me. This shall also serve as authorization by me for PT& Sports Rehab of the Highland Lakes, Inc. to release information to financial or health organizations, physicians, surveyors, reviewers, and clinical students/interns. I understand my rights as a patient, as well as the duty for PT & Sports Rehab to protect my confidential healthcare information as dictated y HIPPA.

ASSIGNMENT OF BENEFITS: I authorize and direct my insurance company(s) to pay on my behalf any and all benefits due me by reason of services rendered by PT &Sports Rehab of the Highland Lakes, Inc., directly to its administrative office at: PT & Sports Rehab of the Highland Lakes, Inc., PO BOX 476, Marble Falls, TX 78654***. I understand that if my insurance company(s) does not make payment, I will be responsible for any and all charges.*** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

As a courtesy, we have contacted your insurance and are following what they have stated about your policy benefits. To avoid any misunderstanding regarding your benefits, it is very important that you personally verify your insurance benefits for physical therapy. Ultimately this is your responsibility to understand what you have chosen for insurance coverage/benefits. Your understanding the benefits that you agreed to with your insurance company is vital to prevent any future surprises/misunderstandings regarding your financial responsibility, if any, for the therapy services rendered to you. **By signing below, you are stating that you understand that you are responsible for any financial obligations based on the agreement you have made with your insurance company policy including co-pay, coinsurance (% of charges) and or any deductible you may have.**

I understand and agree to pay the following deductible of $_____, a Coinsurance of _____% of my insurances allowed amount of $_____ equal to $_____per visit and a Co-pay of $_____per visit as directed by the insurance plan I voluntarily chose to cover my healthcare needs.

_____ _____ _____

Patient Signature Date Therapist

PT and Sports Rehab

of the Highland Lakes

Please select all that applies to your needs, Date and Sign below

PROTECTED HEALTH INFORMATION

Please see checked boxes below for authorization of PHI: (i.e.: surgery type, date, location, Diagnostic type, date, location, etc.)

□ Yes □ No Leave results/PHI on answering machine and/or voicemail

□ Yes □ No Number(s) authorize to leave messages regarding PHI

1. _____
2. _____
3. _____

Persons authorized to receive PHI

_____ (____) _____ _____Name phone relationship

_____ (____) _____ _____Name phone relationship

Billing statements and correspondence:

Any correspondence related to your health information will be automatically mailed to your home address unless indicated otherwise.

If no, Please provide alternative address:

Address City State Zip Code

I _____ acknowledge in signing this document, that I am giving PT and Sports Rehab permission to release PHI (Private Health Information) to specified people and place listed above.

_____ _____

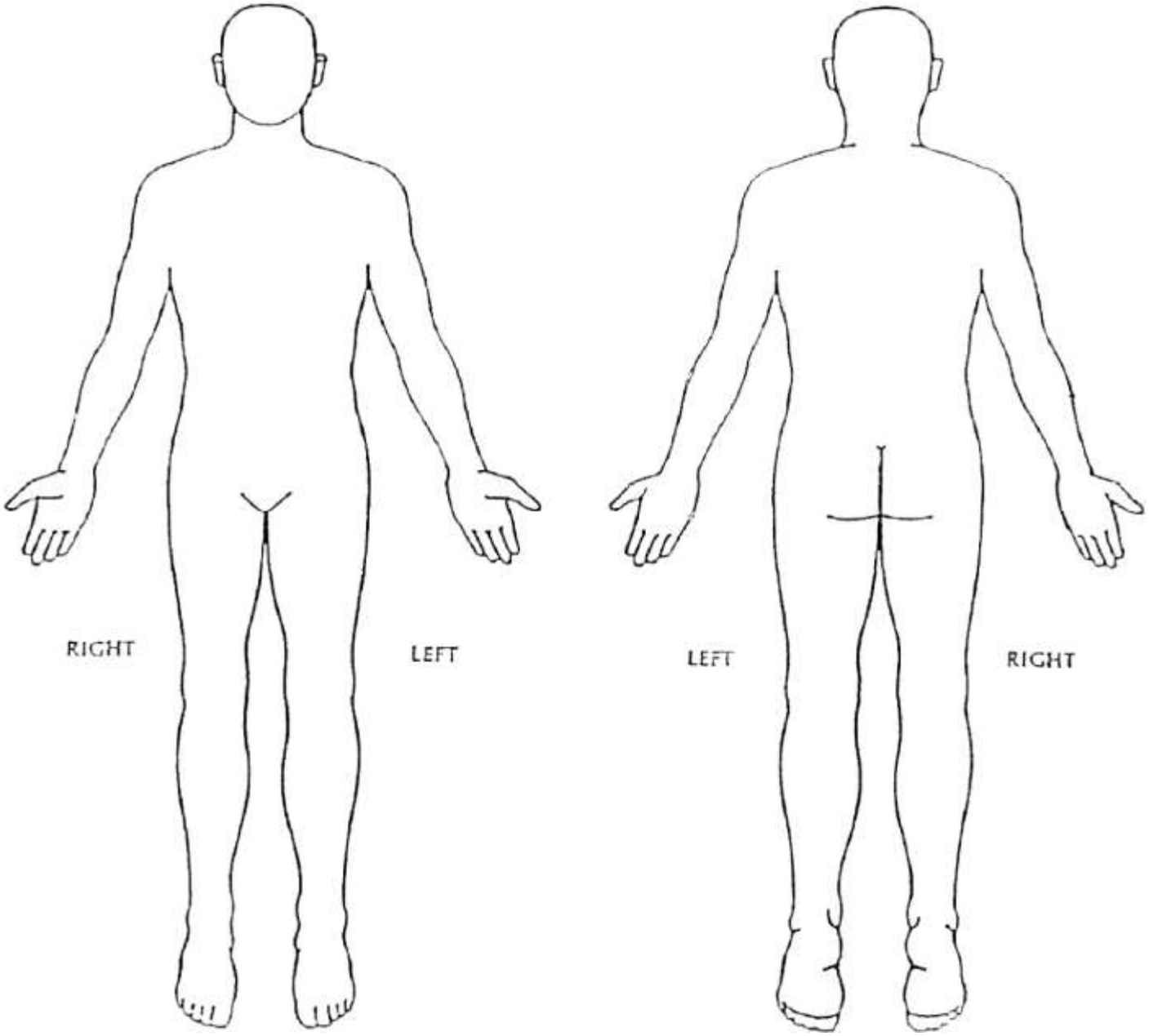
Patient Signature Date

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Include all affected areas. Use the appropriate symbol:

ACHE /\/\/\ NUMBNESS oooo PINS & NEEDLES ::::::::::::::::

BURNING XXXX STABBING ////



FRONT **BACK**

Name: _____ **Date:**_____