BUCKS PHYSICAL THERAPY AND SPORTS REHABILITATION

MEDICARE PATIENT INFORMATION FORM

LAST NAME: _________________________________ FIRST NAME:_________________________________

ADDRESS:____
STREET CITY STATE ZIP

HOME PHONE: ____________________ CELL PHONE: ___________________ EMAIL ADDRESS: ____________________

DATE OF BIRTH: _____/______/_______ SS#: _______-_______-_______ MALE: _____ FEMALE: _____

WHERE INJURY OCCURRED: WORK _________ HOME _________ AUTO _________ OTHER _________________

DATE OF INJURY: ______/______/_______ REFERRING MD: _____________________ HEIGHT: _________ WEIGHT: _______

ACCIDENT INFORMATION

CLAIM NUMBER: ____________________________________ ADJUSTER NAME: _________________________________

INSURANCE NAME: ____________________________________ INSURANCE PHONE NUMBER: _________________________

CLAIM MAILING ADDRESS: ____
STREET CITY STATE ZIP

PRIMARY HEALTH INSURANCE

INSURANCE NAME: ____ ID #: __________________________________

GROUP #: __________________________________ SUBSCRIBER NAME: ____

SUBSCRIBER D.O.B. : ______/______/_______ RELATIONSHIP TO SUBSCRIBER: ______________________________________

SUBSCRIBER ADDRESS (if different): ____
STREET CITY STATE ZIP

SECONDARY HEALTH INSURANCE

INSURANCE NAME: ____ ID #: _________________________________

GROUP #: __________________________________ SUBSCRIBER NAME: ____

SUBSCRIBER D.O.B. : ______/______/_______ RELATIONSHIP TO SUBSCRIBER: _____________________________________

SUBSCRIBER ADDRESS (if different): ____
STREET CITY STATE ZIP

ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE: I authorize payment of medical benefits to BUCKS PHYSICAL THERAPY AND SPORTS REHABILITATION for services rendered to me while under their care. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have. If for any reason me account should become delinquent, I agree to pay for all collection and legal fees.

AUTHORIZATION TO RELEASE INFORMATION: I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and understand my rights under the federal privacy standards. Furthermore, I authorize the release of any medical information necessary to evaluation and treating my medical condition, obtaining payment from insurance companies, public health reporting and if requested by certain law enforcement agencies

SIGNATURE: ____ DATE: ________________________________

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS, COMMENTS ON ALL POSITIVE ANSWERS IN THE SPACE PROVIDED INCLUDING ALL APPROPRIATE INFORMATION AND YEAR OF OCCURRENCE.

Please describe, in your own words, the symptoms or discomfort that prompted you to seek physical therapy:

____

____

During the past year, have you had any physical therapy or chiropractic treatment for any conditions (current or prior):

____

PAST ILLNESSES OR MEDICAL PROBLEMS

HAVE YOU EVER HAD:	YES	NO	COMMENTS
Addiction to Drugs / Alcohol			
Allergies / Skin Problems			
Asthma / Bronchitis			
Arthritis			
Appendicitis			
Anemia, Leukemia			
Back Injury / Concussion			
Cancer			
Diabetes			
Eye / Ear Problems			
Epilepsy / Seizures			
Fainting Spells / Dizziness			
Fractures / Dislocations			
Frequent Colds			
Heart Trouble			
Heat Exhaustion			
Hepatitis			
Hernia			
High / Low Blood Pressure			
Kidney / Bladder Problems			
Mental Illness / Nervous Breakdown			
Mononucleosis			
Neck Injury			
Osteoporosis / Osteopenia			
Ulcer / Stomach Trouble			
Family history of high blood pressure?			
Are you pregnant?			
Ever had surgery? If so, what kind?			
Ever been hospitalized? If yes, why?			
Do you have any illness/injury not mentioned above? Describe.			

AUTHORIZATION TO RELEASE INFORMATION: I acknowledge receipt of the privacy practices and understand my rights under the federal privacy standards. Furthermore, I authorize release of any medical information necessary to treating my medical condition, obtaining payment from insurance companies, public health reporting and if requested by law enforcement agencies.

SIGNATURE: ____ DATE: __________________________

PAIN DISABILITY INDEX

Please circle your current pain level for the following activities:

Family/Home Responsibilities

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Recreation

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Social Activity

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Occupation

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Sexual Behavior

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Self-Care

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Life-Support Activity

10 9 8 7 6 5 4 3 2 1 0

Total Disability Severe Moderate Mild No disability

Total: __________________ Height:____________________ Weight: ___________________