



**PATIENT INFORMATION SHEET**

Patient to fill out highlighted sections

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ PT: \_\_\_\_\_ NP/ONP Acct #: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone# \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Date Info Taken: \_\_\_\_\_ Emp. Initials: \_\_\_\_\_ Fin. Class: \_\_\_\_\_

(Patient to fill out.)

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: \_\_\_ Marital Status: \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
 Current Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Student: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Auto Related? Yes/No If Yes What State: \_\_\_\_\_ Work Related? Yes/No \_\_\_\_\_  
 Date of Injury/Accident: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

(Office use only)

Primary INS: _____	Secondary INS: _____
Address: _____	Address: _____
Phone #: _____	Phone#: _____
Cardholder's Name/DOB/SS# : _____	Cardholder's Name/DOB/SS#: _____
Policy#, Claim#: _____	Policy#, Claim#: _____
Auth#: _____ Group#: _____	Auth#: _____ Group#: _____
Benefits: _____	Benefits: _____
Payor ID: _____ Payment Due: _____	Payor ID: _____ Payment Due: _____
Adj./NCM: _____ Fax#: _____	Adj./NCM: _____ Fax#: _____
Verified With: _____	Verified With: _____
Date: _____ Initials: _____	Date: _____ Initials: _____



PERSONAL HISTORY & SOCIAL SERVICES SCREENING FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date of injury: \_\_\_\_\_

History of injury to same area: \_\_\_\_\_

Did you have surgery? \_\_\_ Yes \_\_\_ No If yes, date of surgery: \_\_\_\_\_

PRESENT EMPLOYMENT:

Occupation: \_\_\_\_\_

Job duties: \_\_\_\_\_

Are you currently working? \_\_\_ Yes \_\_\_ No

If no, off work since \_\_\_\_\_ Expected return date \_\_\_\_\_

PRIOR LEVEL OF FUNCTION:

What could you do before this episode of disability that you cannot do now? \_\_\_\_\_

Are you: Right Hand dominant \_\_\_\_\_ Left Hand dominant \_\_\_\_\_

Current Medications/allergies to medication:

\_\_\_\_\_

MEDICAL CONDITIONS: Check any condition which you have or had

- \_\_\_ High blood pressure \_\_\_ Bleeding disorder \_\_\_ Heart disease
\_\_\_ Stroke \_\_\_ Pace maker \_\_\_ Epilepsy
\_\_\_ Circulation disorder \_\_\_ Ears-hearing aid \_\_\_ Diabetes
\_\_\_ Allergies \_\_\_ Eyes-glasses, contacts \_\_\_ Respiratory
\_\_\_ Pregnant - due date \_\_\_ Asthma \_\_\_ Cancer
\_\_\_ Arthritis \_\_\_ Metal implants (Prosthetic, IUD, bullet)
\_\_\_ Major surgery: Date(s)/Procedure(s) \_\_\_\_\_

Other: \_\_\_\_\_

SOCIAL HISTORY:

Do you consume alcoholic beverages? \_\_\_\_\_ Nicotine? \_\_\_\_\_ How often? \_\_\_\_\_

Describe home environment (multi story, multi step entry) \_\_\_\_\_

Do you have assistance available at home (spouse, child, other)? \_\_\_\_\_

SOCIAL SERVICES SCREEN (to be completed with therapist)

PATIENT REPORTS:

- \_\_\_ No social services intervention is necessary at this point in time
\_\_\_ Social services evaluation is requested for current emotional/functional distress

THERAPIST ASSESSMENT:

- \_\_\_ No social services intervention is necessary at this point in time
\_\_\_ Social services evaluation is requested for current emotional/functional distress

ACTION:

- \_\_\_ No intervention necessary \_\_\_ Patient refuses social services evaluation
\_\_\_ Referral to social services made

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION &  
AUTHORIZATION OF ASSIGNMENT OF BENEFITS**

We strongly feel that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

**PLEASE READ AND INITIAL THE FOLLOWING:**

- I authorize this office to release or receive any information necessary to expedite insurance claims.
- I hereby authorize this office to bill my insurance company directly for their services.
- I authorize payment directly to this provider of my insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable.
- I hereby authorize the above physical therapist(s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize the Tallahassee Orthopedic & Sports Physical Therapy to perform any service (evaluation, treatment procedures & testing) necessary for my rehabilitation.
- Tallahassee Orthopedic & Sports Physical Therapy is granted permission to release to the insurance carrier, employer, attorney, their representatives or referring physician, any information in connection with any treatment rendered to patient or patient's behalf at any time such information is requested.
- HIPAA – I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I understand that I am directly & completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance carrier fails to pay my balance in full, or there is no payment made within 45 days, it is my responsibility to pay my balance directly. At 90 days, if no payment is made on my account interest will start accruing at 1 ½ % per month. I further understand & agree that if I fail to make timely payments on my account, I will be responsible for any & all-reasonable costs of collection including filing fees as well as reasonable attorney's fee.

A Photostat copy of these authorizations and agreements shall be as valid as original.

\_\_\_\_\_  
PATIENT OR GUARDIAN (PRINT)                      PATIENT OR GUARDIAN SIGNATURE                      DATE

**All students must complete this section with a permanent address & the responsible party's information:**

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Name & Address \_\_\_\_\_ Phone \_\_\_\_\_

Reason why above is responsible \_\_\_\_\_