

**PATIENT RECORD**

*Please fill out completely. Thank you*

Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone Number \_\_\_\_\_

City \_\_\_\_\_ ST. \_\_\_\_\_ Zip \_\_\_\_\_ CellPhone: \_\_\_\_\_ Email: \_\_\_\_\_

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Ext. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_

Zip Code \_\_\_\_\_ Title/Dept. \_\_\_\_\_

Are You a Student? \_\_\_\_\_ Married, Single, Divorced, Widowed? \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Cell Phone: \_\_\_\_\_

Responsible Party(if under 18) \_\_\_\_\_

Mailing Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ BirthDate \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Office location: \_\_\_\_\_

Prescribing Doctor \_\_\_\_\_ Office location: \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Date of Injury \_\_\_\_\_

Was This Work Related? \_\_\_\_\_ An Auto Accident? \_\_\_\_\_ Other Accident? \_\_\_\_\_

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**How did you hear about us? Return patient? \_\_\_\_\_ Doctor? \_\_\_\_\_**

**Friend? \_\_\_\_\_ Phone Book? \_\_\_\_\_ Other? \_\_\_\_\_**

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*If your insurance company requires a referral from a physician, it is your responsibility to obtain and provide it to us.*

**PRIMARY INSURANCE POLICY – (We must have a copy of your insurance card.)**

Company \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB of Insured: \_\_\_\_\_

**Do you have a Secondary Insurance? Company: \_\_\_\_\_**

**Name of Insured: \_\_\_\_\_ DOB of Insured: \_\_\_\_\_**

# Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

DOB: \_\_\_\_\_

**Current Complaints:**

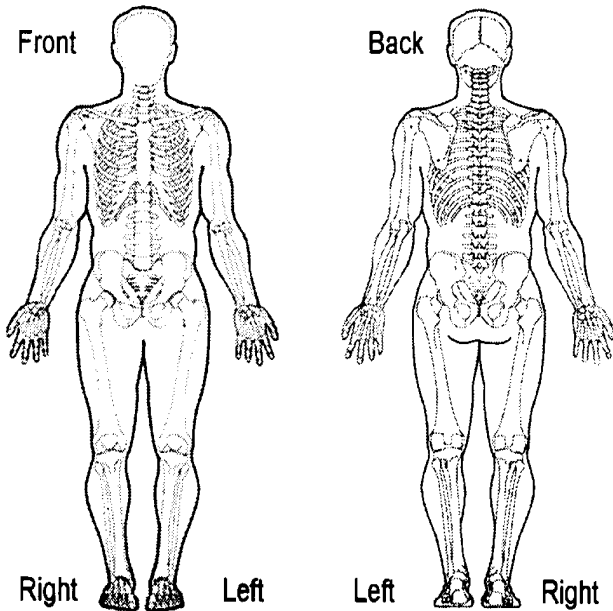
- |          |                |               |   |   |
|----------|----------------|---------------|---|---|
| 1. _____ | How Long _____ | Prior History | Y | N |
| 2. _____ | How Long _____ | Prior History | Y | N |
| 3. _____ | How Long _____ | Prior History | Y | N |

Have you been treated for the above problems: If so, by whom:

\_\_\_\_\_

Place 'X' at location of pain:

Pain Scale:



Indicate Pain Severity by Circling Number:

0 1 2 3 4 5 6 7 8 9 10 more

**Previous Medical History:**

Place an "X" indicating Current or Past Medical Issues

|                                      |  |                     |  |
|--------------------------------------|--|---------------------|--|
| Changes in bowel or bladder function |  | Cancer              |  |
| Recent Weight Gain                   |  | High Blood Pressure |  |
| Recent Weight Loss                   |  | Diabetes            |  |
| Fatigue, more than usual             |  | Fainting/Dizziness  |  |
| Nausea                               |  | Depression          |  |
| Numbness                             |  | Night Sweats        |  |
| Other Medical Concerns:              |  |                     |  |

|  |                     |                         |                     |
|--|---------------------|-------------------------|---------------------|
| <b><u>Surgeries:</u></b> (Use reverse side for additional writing space) | <b><u>Date:</u></b> | <b><u>Injuries:</u></b> | <b><u>Date:</u></b> |
| _____  | _____               | _____                   | _____               |
| _____  | _____               | _____                   | _____               |
| _____  | _____               | _____                   | _____               |

**Current Medications:** (Use reverse side for additional writing space)

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Therapist Notes**

## Consent for Treatment and Uses of Healthcare Information for Purposes of Payment and Healthcare Operations

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Rakita and Tomsic Physical Therapy, Inc. I consent to the release to and, use by, or disclosure of my protected health information to and by Rakita & Tomsic Physical Therapy, Inc., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Rakita & Tomsic Physical Therapy, Inc. I understand that diagnosis or treatment of me by David N. Rakita, Ellen M. Tomsic or their associates, may be conditioned upon my consent as evidenced by my signature on this document

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Any and all protected health care information may be disclosed at any time to: \_\_\_\_\_ whose relationship to me is \_\_\_\_\_.

Rakita & Tomsic Physical Therapy, Inc. is not required to agree to the restrictions that I may request. However, if Rakita & Tomsic Physical Therapy, Inc. agrees to a restriction that I request, the restriction is binding on Rakita & Tomsic Physical Therapy, Inc., David N. Rakita, Ellen M. Tomsic and/or their associate. I have the right to revoke any and all consent, in writing, at any time, except to the extent that David N. Rakita, Ellen M. Tomsic or Rakita & Tomsic Physical Therapy, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

**I understand that Rakita and Tomsic Physical Therapy will bill my insurance as a courtesy to me and any payment disputes are between me and my insurance company. I authorize my insurance company to pay, directly to Rakita and Tomsic Physical Therapy, Inc, all benefits due me under the provisions of my policy. I understand and accept that, although I may be covered by insurance, I am personally responsible for all charges incurred for services rendered to me. I accept liability for all charges not paid for by the insurance, third party or other source.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand I have a right to review Rakita & Tomsic Physical Therapy, Inc.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Rakita & Tomsic Physical Therapy, Inc.

The Notice of Privacy Practices for Rakita & Tomsic Physical Therapy, Inc. is also provided at the reception desk in the office of Rakita & Tomsic Physical Therapy, Inc. This notice of Privacy Practices also describes my rights and Rakita & Tomsic Physical Therapy, Inc.'s duties with respect to my protected health information. Rakita & Tomsic Physical Therapy, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority