PATIENT INFORMATION

Last Name ________________ Legal First Name ________________ Date of Birth___________

Preferred Name ____ Gender ☐ Male ☐ Female

Address ____

Doctor________________________ Diagnosis ____________ Date Problem Began ______

Home Phone ______________ Work phone ________________ Cell Phone ________________

Email ____

Have you had Speech Therapy, OT, or PT this calendar year? ___ Yes ____ No

If So: How Many Visits? _____________ Where? ____________________

Marital Status: ____Single ____Divorced ____Married ____Widowed

Spouse's Name__________________ Spouse's DOB _______________

Spouse's Cell phone _______________ Work phone________________

How would you like appointment reminders?

__ Text
__ Email
__ Neither

Cell Phone Carrier
(If text preferred)

____

INSURANCE

Primary Insurance ___________________________ **(Please provide a copy of your insurance card)**

Name of Subscriber ____________________ Relationship ______________________________

Subscriber's Date of Birth ________________

Secondary Insurance _________________________ **(Please provide a copy of your insurance card)**

Name of Subscriber ____________________ Relationship _____________________________

Subscriber's Date of Birth ________________

Worker's Compensation and/or Accident (if yes, which one?):______________________________

Name of Employer _______________________Employer Phone Number _____________

Employer's Address ____

Name of Claim Adjuster ____

Worker's Comp. Phone # (for claim adjuster) _____________________________________

IN CASE OF EMERGENCY

Emergency Contact (other than spouse) ____

Phone Number ____

How did you hear about our clinic? ____

MEDICAL HISTORY FORM

Do you have now or have you ever had any of the following conditions? (Please check Yes or No)

CARDIOVASCULAR

Yes No
- ☐ ☐ High Blood Pressure
- ☐ ☐ Chest Pain
- ☐ ☐ Heart Attack
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Abnormal EKG / Stress Test
- ☐ ☐ Taking Anticoagulants
- ☐ ☐ Stroke
- ☐ ☐ Defibrillator
- ☐ ☐ Pacemaker

PSYCHIATRIC

Yes No
- ☐ ☐ Depression
- ☐ ☐ Anxiety

PULMONARY

Yes No
- ☐ ☐ COPD or Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Shortness of Breath
- ☐ ☐ Use Oxygen (O2) at home
- ☐ ☐ Tobacco Use

MUSCULOSKELETAL

Yes No
- ☐ ☐ Pain in Joints
- ☐ ☐ Swelling in Joints
- ☐ ☐ Artificial Joint
- ☐ ☐ Osteoporosis / Osteopenia

OTHER SYSTEMIC

Yes No
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid Abnormality
- ☐ ☐ Bladder Problems
- ☐ ☐ Bleeding Disorder
- ☐ ☐ History of HIV
- ☐ ☐ History of Hepatitis
- ☐ ☐ Pregnancy (or trying?)

NEUROLOGIC

Yes No
- ☐ ☐ Fainting / Seizures
- ☐ ☐ Dementia
- ☐ ☐ Parkinson's

Is there anything else you would like for your therapist to know? Yes No

If yes, explain ______________________________

Do you have any allergies? ______________________________

****List all medications you are currently taking (include OTC, herbals, supplements, vitamins, or attach list):**

Name	Dosage	How often?	How taken (oral/
1.			
2.			
3.			
4.			
5.			
6.			

Please list any surgical procedures you have had.

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Print Name: ____________________

Signature: ____________________ Date: ____________________

Birmingham Physical Therapy & Sports Medicine

3234 Cahaba Heights Road
Vestavia Hills, AL 35243
Phone (205) 298-9101 Fax (205) 298-9103

Consent for Physical Therapy Treatment
Authorization for Release of Information

Consent for Physical Therapy: I hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand that diagnosis and treatment may involve risks or injury. I acknowledge that no guarantees have been made to me as a result of examination or treatment. I hereby authorize Ellen Hamilton and **Birmingham Physical Therapy & Sports Medicine, Inc,** to retain any records for use, for research and for teaching purposes.

Consent for Blood Testing: I give my permission for a sampling of my blood to be tested for infectious disease in the event that a therapist or other employee becomes exposed to my blood or bodily fluid.

Authorization for Release of Information: I authorize my referring physician to release any information necessary for my treatment at **Birmingham Physical Therapy & Sports Medicine, Inc.**

Medicare, Title XVIII: The information that I have given for payment application under **Title XVIII** of the Social Security Act is correct. I authorize **Birmingham Physical Therapy & Sports Medicine, Inc** to release any information to the Social Security or its carriers to gather information needed to file this Medicare claim and request payment on my behalf.

Payment of Services: I authorize any release of medical information that is required for payment owed by me to **Birmingham Physical Therapy & Sports Medicine, Inc.** I agree that **Birmingham Physical Therapy & Sports Medicine, Inc** will not be responsible for confidentiality of any documents released to any insurance carrier or other entity responsible for payment of my healthcare costs. I authorize payment from any third payer to be made directly to **Birmingham Physical Therapy & Sports Medicine, Inc.**

I understand that I am financially responsible to pay all costs and fees to **Birmingham Physical Therapy & Sports Medicine, Inc** that are not covered by my insurance company. I agree to pay collection costs including attorney fees incurred by **Birmingham Physical Therapy & Sports Medicine, Inc** related to collecting costs and fees charged to me for all services rendered and goods provided in the event of failure to pay all debts.

We are committed to provide the best service possible for you. Please give us a **24 hour cancellation notice** if you are unable to make your scheduled appointment, so that we might notify other patients who may need treatment. Please also **refrain from using any other source for cancellation other than by phone.**

Please initial on the lines below:

______**I understand there is a $30.00 fee for missing an appointment without 24 hour notice.**

______**I understand that payment is due at time of service. I understand that the amount collected at the time of service is an estimate based on the best information available from my insurance company.**

Patient: ______________________________ Date: ________________
(or signature of parent if patient is a minor)

Witness: ______________________________ Date: ________________