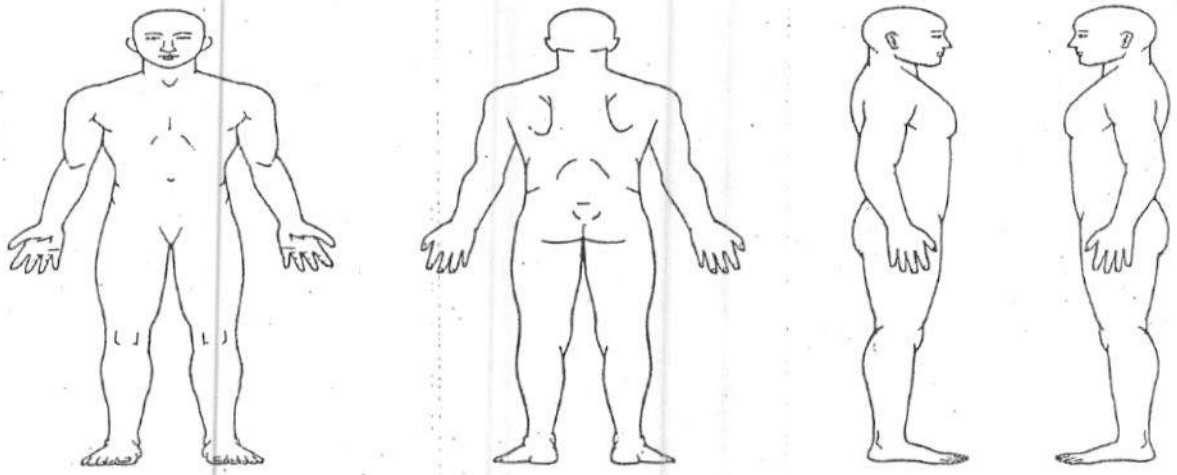
MEDICAL HISTORY FORM

Name _____ Date of Birth_____

Age_____ Weight_____ Height_____

Please circle the area (s) you are having pain:



Please list:

Diagnostic Tests (MRI/XRAY/CT scan): _____

Surgeries/Hospitalizations: _____

Medications: _____

Please check the following that apply:

Unexplained weight loss	☐	Respiratory problems	☐	COPD	☐
Night pain	☐	Dizziness	☐	Ehlers-Danlos	☐
Fever/Chills	☐	Headaches	☐	Lymphedema	☐
Fractures	☐	Cardiac problems	☐	Multiple sclerosis	☐
Arthritis	☐	Metal implants	☐	Parkinson's	☐
Numbness/Tingling	☐	Thyroid problems	☐	Rheumatoid arthritis	☐
Depression	☐	Anxiety	☐	Pacemaker	☐
Diabetes	☐	Substance abuse	☐	Anemia	☐
High blood pressure	☐	Low blood pressure	☐	Cancer	☐
Allergies	☐	Steroid use (corticosteroids)	☐	Urinary incontinence	☐
Osteoporosis/Osteopenia	☐	Recent falls	☐		

Any other medical condition: _____

Patient Signature: _____ Date:_____

Reviewed By: _____ Date:_____

PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home:	☒	
Work:	☐	
Cell:	☐	

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: N/A

Preferred language: EN English **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

PATIENT EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

SPOUSE EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient **Date**

SPORT & SPINE CLINIC OF FORT ATKINSON
PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
SPORT & SPINE CLINIC OF FORT ATKINSON
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**_____

LIABILITY

I know and agree that: SPORT & SPINE CLINIC OF FORT ATKINSON
is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: SPORT & SPINE CLINIC OF FORT ATKINSON
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:**_____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: SPORT & SPINE CLINIC OF FORT ATKINSON
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:**_____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:**_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:**_____
I acknowledge receipt of the Statement of Patient Rights. **Initials:**_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Witness Signature _____