# ORTHOPAEDICS PHYSICAL THERAPY plus

## Patient Information

***** = Required Information***

**Last Name**:** _____
**First Name**:** _____
**Date of Birth**:**_____

**EMAIL**:**_____

**Address**:** _____
**Apt or PO Box**:**_____
**City**:** _____
**State**:** _____
**Zip**:** _____

**Cell Phone**:** _____
**Home Phone:** _____
**Work Phone:** _____

## How did you hear about us?** *(circle one of the following)*:

| | | | |
|---|---|---|---|
| Search Engine | Friend/Family | Yelp | Ads (Google) |
| Seminar/Lecture | Previous Patient | Doctor | Ads (Facebook) |
| Article/blog/video | Our Website | Other-------> | |

## Appointment Reminders *(circle one of the following):*

TEXT MESSAGE // EMAIL

If text message, choose your carrier:
☐AT&T ☐MetroPCS ☐Sprint ☐T-mobile ☐US Cellular ☐Verizon ☐Other: _____

## Emergency Contact

***** = Required Information***

**Last Name**:** _____
**First Name**:** _____
**Phone**:** _____
**Relationship**:** _____

***~~~~~~~~~~~~~~~~PLEASE PROCEED TO OTHER SIDE~~~~~~~~~~~~~~~~***

NAME:

## Primary Insurance *** = Required Information* *Please provide your insurance card so we can make a copy*

**Insurance**:** _____

**ID Number**:** _____

**Subscriber Relation to Patient**:** _____

☐Self ☐Spouse ☐Parent ☐Other

**Subscriber Name**:** _____

**Subscriber Date of Birth**:** _____

**Subscriber Address**:** ☐Same as above ☐Other:

## Referral Information *** = Required Information*

**Referred by**:** _____

**Primary care Physician**:** _____

**When did this problem start?**:** _____

## Secondary Insurance *(if applicable)* *** = Required Information*

**Insurance**:** _____

**ID Number**:** _____

**Subscriber Relation to Patient**:** _____

☐Self ☐Spouse ☐Parent ☐Other

**Subscriber Name**:** _____

**Subscriber Date of Birth**:** _____

**Subscriber Address**:** ☐Same as above ☐Other:

**Is this employment related or a result of a motor vehicle accident?**** ☐YES ☐NO

*(if yes, please see front desk staff)*

**Have you been seen by a Physical Therapist for any problem elsewhere within the past year: ☐YES ☐NO**

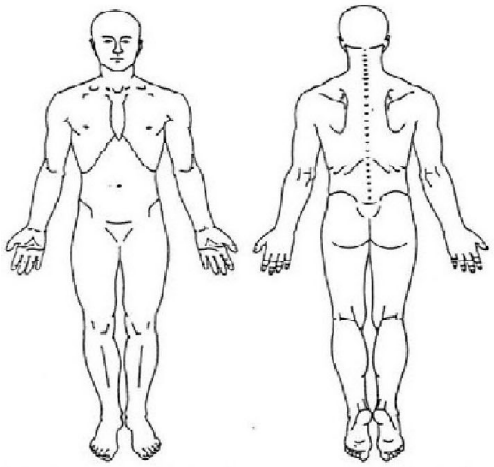
*If yes, how many visits:*

***~~~~~~~~~~~~~~~~PLEASE PROCEED TO OTHER SIDE~~~~~~~~~~~~~~~~***

NAME:

## Problem *** = Required Information***

***On the diagram below, please mark where you are experiencing your symptoms:***



On a scale of 1 to 10 (10 being emergency room pain) how painful is it (circle):

Today? 0 1 2 3 4 5 6 7 8 9 10

At its best? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms (ie: achy, sharp, numbness, tingling...):_____

_____

What activities or positions do you have difficulty with, avoid, or are unable to do?

_____

What eases your symptoms?_____

## Past Medical History

**Do you now or have you ever had any of the following?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Asthma, Bronchitis, or Emphysema | ☐YES | ☐NO | High Blood Pressure | ☐YES | ☐NO | Anemia | ☐YES | ☐NO |
| Shortness of Breath/Chest Pain | ☐YES | ☐NO | Heart Attack or Surgery | ☐YES | ☐NO | Diabetes | ☐YES | ☐NO |
| Coronary Heart Disease or Angina | ☐YES | ☐NO | Thyroid Trouble/Goiter | ☐YES | ☐NO | Gout | ☐YES | ☐NO |
| Cancer/chemotherapy/Radiation | ☐YES | ☐NO | Dizziness or Fainting | ☐YES | ☐NO | Weakness | ☐YES | ☐NO |
| Emotional/Psychological Problems | ☐YES | ☐NO | Infectious Diseases | ☐YES | ☐NO | Hernia | ☐YES | ☐NO |
| Bowel or Bladder Problems | ☐YES | ☐NO | Numbness or Tingling | ☐YES | ☐NO | Allergies | ☐YES | ☐NO |
| Severe or Frequent Headaches | ☐YES | ☐NO | Elbow/Hand Injury | ☐YES | ☐NO | Osteoporosis | ☐YES | ☐NO |
| Vision or Hearing Difficulties | ☐YES | ☐NO | Neck Injury/Surgery | ☐YES | ☐NO | Stroke/TIA | ☐YES | ☐NO |
| Sleeping Problems/Difficulties | ☐YES | ☐NO | Back Injury/Surgery | ☐YES | ☐NO | Blood Clot/Emboli | ☐YES | ☐NO |
| Leg/Ankle/Foot Injury/Surgery | ☐YES | ☐NO | Knee Injury/Surgery | ☐YES | ☐NO | Epilepsy/Seizures | ☐YES | ☐NO |
| Do you have a Pacemaker? | ☐YES | ☐NO | Arthritis/Swollen Joints | ☐YES | ☐NO | Varicose Veins | ☐YES | ☐NO |
| Any Pins or Metal Implants? | ☐YES | ☐NO | Are You Pregnant? | ☐YES | ☐NO | Joint Replacement | ☐YES | ☐NO |
| Weight Loss/Energy Loss | ☐YES | ☐NO | Do You Smoke? | ☐YES | ☐NO | | | |

*If you answered yes to any of the above, please describe:*_____

_____

**Please list all medications and dosages** *(or provide a copy of your list)***:**

| *Medication* | *Dosage* |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

***~~~~~~~~~~~~~~~~PLEASE PROCEED TO OTHER SIDE~~~~~~~~~~~~~~~~***

NAME:

**Patient Agreement:**
- I authorize Orthopaedics Plus to disclose my appointment information as indicated above.
- I understand my rights and responsibilities as a patient.
- I authorize release of information requested by my insurance plan for payment.
- I understand that I am responsible for any balance due.
- I agree to comply with the terms and conditions as outlined in the Patient Registration form.

Signature of Patient or Guardian: _____ Date ____/____/_____

**Notice of Payment Policies:**
- I hereby acknowledge that I have have read and understand Orthopaedics Plus's payment policies, including the copayment/co-insurance policy, no show and late cancel policy, and the applied balances policy.

Signature of Patient or Guardian: _____ Date ____/____/_____

**Notice of Privacy Practices:**
- I hereby acknowledge that I have have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Guardian: _____ Date ____/____/_____

**Consent to Treatment:**
- I consent to receive physical therapy services and any services that are deemed medically necessary/appropriate by my physical therapist and/or treating physician. I am also aware that the practice of physical therapy is not an exact discipline and acknowledge no guarantees have been made regarding treatment and treatment results from physical therapy.

Signature of Patient or Guardian: _____ Date ____/____/_____

**Email Correspondence:**
In efforts to provide our patients with great customer service and the latest information regarding all of our services, you may periodically receive emails from our company. If you prefer NOT to get these emails, please check the box below:

☐ Opt out of email correspondence

***~~~~~~~~~~~~~~~~PLEASE PROCEED TO OTHER SIDE~~~~~~~~~~~~~~~~***