DE SOTO
PHYSICAL THERAPY

# Patient Data Sheet

NAME: _____
LAST FIRST MIDDLE

MAILING
ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME( ____ ) _____ WORK( ____ ) _____ EMAIL: _____

PREFERRED WAY TO CONTACT YOU: ☐ HOME ☐ WORK ☐ CELL

SEX: ☐ M ☐ F DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ OTHER _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____ PHONE: ( ____ ) _____
NAME/RELATION

HOW DID YOU HEAR ABOUT US? _____

**RESPONSIBLE PARTY:** IF THE PRIMARY INSURED IS DIFFERENT FROM ABOVE, PLEASE FILL OUT THIS SECTION:

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ OTHER _____

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY/STATE/ZIP

PHONE: HOME( ____ ) _____ WORK( ____ ) _____ CELL( ____ ) _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER NAME: _____ ADDRESS: _____

**INSURANCE INFORMATION**

PRIMARY
INSURANCE NAME:

POLICY NUMBER: _____

SECONDARY
INSURANCE NAME: _____

POLICY
NUMBER: _____

**OFFICE USE ONLY:**

CASE ID: _____

ICD10(s): _____

CAUSE: _____

REF PHYS: _____ FREQ/DUR: _____

FILED: FOLDER_____ eDocs_____

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**Name:** _____ Today's Date: _____

Height: _____ Weight: _____ Age: _____ **Are you:** ( ) Right handed ( ) Left handed

**General Health:** Please rate your health:

Excellent Good Fair Poor

**Medications:**

Do you take any prescription medications? ____ Yes No If yes please list:

Medication (include Dosage & Frequency):

_____

_____

_____

**Allergies:**

Do you have a Latex/Rubber allergy? ____ Yes No

Do you have any other allergies? ____ Yes No

If yes, please list: _____

Do you take any nonprescription medications or supplements? ____ Yes No

If yes, what? _____

**History of Current Problem(s)**

When did the problem(s) begin? _____ / _____ / _____ What happened? _____

Have you ever had the problem(s) before? ____ Yes No

What did you do for the problem(s)? _____

Did the problem(s) get better? ____ Yes No

About how long did the problem(s) last? _____

How are you taking care of the problem(s) now? _____

What makes the problem(s) worse? _____

What makes the problem(s) better? _____

Are you seeing anyone else for the problem? Check all that apply.)

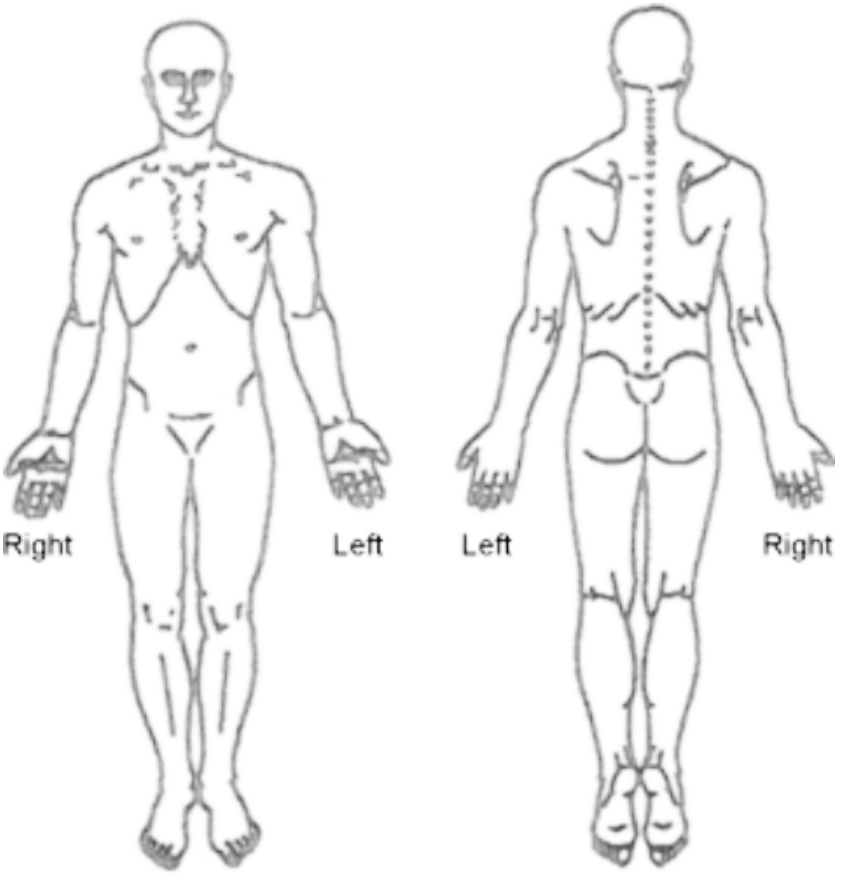
| | | |
|---|---|---|
| ☐ Family Practitioner | ☐ Orthopedist | ☐ Pediatrician |
| ☐ Cardiologist | ☐ Rheumatologist | ☐ Neurologist |
| ☐ Podiatrist | ☐ Occupational therapist | ☐ Speech Therapist |
| ☐ Massage Therapist | ☐ Chiropractor | ☐ Other: _____ |

## Tell me about your pain:

It is important to have a measure of your pain. Please rate the level of your pain on the following scale.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| At present: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At best : | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | (no pain) | | | (moderate) | | | (extreme) | | | | (agony) |

Please indicate painful areas by shading these models.




Which of these words describe your pain? (Circle all that apply)

Sharp Dull Burning Aching Tingling
Numb Constant Variable Radiating (moves)

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## CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **DeSoto Physical Therapy** to furnish medical care and treatment to _____ (print name) that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ Responsible Party Initials

## AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize **DeSoto Physical Therapy** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **DeSoto Physical Therapy** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between **DeSoto Physical Therapy** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize DeSoto Physical Therapy, to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the **DeSoto Physical Therapy** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to **DeSoto Physical Therapy** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and **DeSoto Physical Therapy** will always post the current notice at the clinic and have copies available for distribution.

Indicated below are individuals whom **DeSoto Physical Therapy** may speak regarding my treatment. Please list names.

☐ spouse _____ ☐ father _____

☐ mother _____ ☐ other_____

_____ Responsible Party Initials

I have received and read a copy of the **Notice of Patient Information Practices** (located in New Patient folder).

_____ Responsible Party Initials

## SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent for Use and Disclosure of Health Information.

Patient / Guardian / Responsible Party Signature: _____ Date _____

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2070 Highway 171 Suite A Stonewall, LA 71078 (318) 775-9870

# MEDICATION LIST

Name: _____ Date of Birth: _____

| Medicine Name | Purpose | Dosage | Frequency | Route | Doctor |
|---|---|---|---|---|---|
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