

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
(Please Check)  Dr  Mr  Ms  Mrs  Miss  Male  Female  Jr.  Sr.

ADDRESS \_\_\_\_\_ ZIP CODE \_\_\_\_\_

(Please Check)

RACE  Black  White  Native American  Hispanic  Other \_\_\_\_\_

ETHNICITY  Hispanic  Non-Hispanic  Other \_\_\_\_\_

LANGUAGE  English  Other \_\_\_\_\_

MARITAL STATUS  Married  Single  Divorced  Widowed  Legally Separated

For proper identification in our computer system please provide the following information.  
Your social security number is protected by HIPPA.

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PHONE NUMBERS HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_

ALTERNATE# \_\_\_\_\_ NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_ FAMILY DOCTOR \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

ACCIDENT INFORMATION  WORK \_\_\_\_\_ / \_\_\_\_\_ Claim is:  Denied  Accepted  
DATE STATE  
 AUTO \_\_\_\_\_ / \_\_\_\_\_ \$ Benefits  Available  Exhausted  
DATE STATE

Is your case in litigation?  Yes  No

If yes, please provide:

Attorney's name, phone & FAX number \_\_\_\_\_

Case Manager's name, phone & FAX number \_\_\_\_\_

**INSURANCE INFORMATION**

If you are not the subscriber of your insurance plan please provide the following:

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

RELATIONSHIP TO THE SUBSCRIBER \_\_\_\_\_

PHONE # \_\_\_\_\_ SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_

**CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF VISIT**

For your convenience, we offer the following methods of payment. Please check the option you prefer.

\_\_\_\_\_ Cash

\_\_\_\_\_ Personal Check

\_\_\_\_\_ MC/VISA/AM Express/Discover (\$5.00 minimum)

\_\_\_\_\_ I wish to discuss payment options.

ASSOCIATES IN PHYSICAL MEDICINE & REHABILITATION OF SW PA PC

Consent to Disclosure of Personal Health Information to Family Members

I, \_\_\_\_\_, give my permission to the practitioners and staff of Associates in P M & R to *release* information regarding my medical care, including my medical condition, test results, appointment dates/times and to *obtain* information in order to satisfy any outstanding balance to the following **FAMILY MEMBERS**:

Name	Relationship	Telephone Number
<b>Emergency Contact:</b>		
<b>Other family members who have permission to discuss your care:</b>		

\_\_\_\_\_  
Signature of patient (or personal representative)

\_\_\_\_\_  
Date

Personal Representative Name: \_\_\_\_\_

Relationship/Authority: \_\_\_\_\_

Associates in Physical Medicine and Rehabilitation of SW PA PC

Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat

Associates in PM&R of SW PA PC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Mail: Associates in Physical Medicine & Rehabilitation of PW PA PC
Attention, Privacy Officer
101 Trich Drive, Suite 2
Washington, Pennsylvania 15301
Telephone: 724-223-9270, extension 11
Fax: 724-223-8133

Acknowledgement of Receipt and Consent

I, \_\_\_\_\_, give my consent to the practitioners of Associates in PM &R to perform medical services determined to be necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for Associates in PM&R and they are authorized to use and disclose my protected health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

Medicare, Medicaid and all other(Third Party Payers) Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or third party payors, any information needed for this or a related insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to the insurance carrier for payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or personal representative) \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative Name: \_\_\_\_\_
(IF patient is unable to sign)

Relationship/Authority: \_\_\_\_\_

Good Faith Efforts to Obtain Acknowledgement of Receipt

The above named patient/personal representative was offered the Notice of Privacy Practices.

Describe how notice was provided:

- Offered copy and individual refused to accept delivery
Offered copy and individual accepted delivery
Other:

Describe efforts to obtain signature on acknowledgement of notice form:

- Patient/personal representative was asked to sign form and refused
Other:

Signature of staff member \_\_\_\_\_ Date \_\_\_\_\_



What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

**Have you had?**

**Physical Therapy**     yes  no if YES, name of facility \_\_\_\_\_

**Chiropractic Care**     yes  no if YES, name of facility \_\_\_\_\_

**Diabetic Foot Exam**     yes  no if YES, name of facility \_\_\_\_\_ Date: \_\_\_\_\_ A1C: \_\_\_\_\_

**MEDICATION LIST**    *\*\*\*\*\*Please provide list to the staff\*\*\*\*\**

Name	Dose	Frequency	Prescribing Doctor
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

**ALLERGIES**     No Known DRUG Allergies

Medication(s)  Penicillin     Codeine     Sulfa     NSAIDS     IVP Dye

Other Medications \_\_\_\_\_

Other  Tape     Latex     Seasonal    **Food**  Shellfish     Gluten

Any other: \_\_\_\_\_

**HABITS Smoking Status**     Never smoked     Everyday smoker     Some day smoker     Former smoker

If smoker please circle: Cigarette / Cigar / E-Cigarette or Vape    # \_\_\_\_\_ pack(s) cigarette(s) per week

Smokeless Tobacco Status     Never     Everyday     Former    **Please circle:** Snuff / Tobacco

**ALCOHOL USE**     Non-drinker     Less than 5 drinks per week     6-15 drinks per week     More than 15+  
 Former drinker

SURGICAL HISTORY			DATE
Knee Replacement	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
Knee Arthroscope	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
Hip Replacement	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
Hysterectomy			
Tubal Ligation			
C-Section			
Tonsillectomy			
Bone Fracture Repair			
Prostate Resection (TURP)			

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

<b>SURGICAL HISTORY continued</b>	<b>DATE</b>
Thyroid Removal	
Appendectomy (appendix)	
Cholecystectomy (gallbladder)	
Coronary Artery Bypass Grafting (GABG)/heart bypass	
Posterior Cervical Fusion (neck surgery through the back)	
Discectomy Cervical (surgery for disc herniation in neck, through the front)	
Fusion Lumbar (low back fusion)	
Discectomy Lumbar (surgery for disc herniation low back)	
Rotator Cuff Repair	
<b>List other surgeries:</b>	

**MEDICAL HISTORY**

Check all problems that apply to you NOW or in the PAST.

<b>Heart Conditions</b>	<b>Yes</b>	<b>No</b>	<b>Neurological Conditions</b>	<b>Yes</b>	<b>No</b>
Coronary Artery Disease			Depression		
Irregular Heartbeat			Anxiety		
Valve problem/replacement			Bipolar Disorder		
Heart Attack			Panic Attacks		
Angina			Stroke/CVA		
High Blood Pressure			Headache		
<b>Lung/Breathing Conditions</b>	<b>Yes</b>	<b>No</b>	Drug Dependence		
Asthma			Alcohol Dependence		
Bronchitis			Seizure Disorder/Epilepsy		
COPD			<b>Endocrine Conditions</b>	<b>Yes</b>	<b>No</b>
Lung Cancer			Diabetes		
<b>Eyes/Ears/Nose/Throat</b>	<b>Yes</b>	<b>No</b>	Thyroid Disease		
Glaucoma			Breast Cancer		
Cataracts			Last Menstrual Period (if applicable)		
Sinusitis			<b>GI/Digestive System</b>	<b>Yes</b>	<b>No</b>
Laryngitis			Ulcer Disease		
TMJ Syndrome			Crohn's Disease		
Hearing Loss			Irritable Bowel Syndrome (IBS)		
<b>Genito-Urinary System</b>	<b>Yes</b>	<b>No</b>	Ulcerative Colitis		
Kidney Stone			GI Bleeding		
Prostate Cancer			Hepatitis		
BHP-Benign Prostatic Hypertrophy			Cirrhosis		
Chronic Kidney Disease:			GERD		
Stage: I II III IV V			Hemorrhoids		
			Colon Cancer		

Other Medical Problems: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY HISTORY**

List any medical history which applies to your immediate family.

**SOCIAL HISTORY**

Check all situations that apply to you.

**Employment**

- Full time     Part time     Disabled
- Retired
- Unemployed         Laid off
- Unable to work due to pain

**Student**

- Full Time     Part time
- Unable to attend school due to pain

**Special Living Arrangements**

- Assisted Living Facility
- Living Temporarily  
(at shelter or mission, with friends, or half way house)
- Skilled Nursing Facility

**Martial/Child Status**

- Married                       Single
- With children               No children
- Pregnant- # of months: \_\_\_\_\_

***Have you had any of the following symptoms over the past three months?***

	Yes	No		Yes	No
Weight loss more than 10 lbs.			Diarrhea		
Weight gain more than 10 lbs.			Constipation		
Fevers or chills			Loss of bowel control/incontinence)		
Night sweats			Blurry vision		
Loss of appetite			Double vision		
Skin rashes			Loss of vision		
Easy bruising			Burning on urination		
Sore throat			Bleeding on urination		
Hearing loss			Loss of bladder control/incontinence)		
ringing in ears			Missed most recent menstrual period		
Shortness of breath at rest			Loss of memory/confusion		
Shortness of breath with exercise			Weakness		
Coughing			Seizures or convulsions		
Chest pain			Dizziness or lightheaded		
Heart racing, palpitations			Passing out episodes		
Swelling of the ankles			Feelings of depression or sadness		
Stomach pain			Stress increases pain		
Nausea			Difficulty sleeping		
Vomiting			Increased irritability		

Revised March 2018

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_