# BUCKEYE PHYSICAL MEDICINE AND REHAB - HILLIARD PATIENT INTAKE

GENERAL INFORMATION					
Name: (Age) Gender: M F					
Home Address: Home Phone:					
City, State, Zip: Work Phone:					
Email Address:          Cell Phone:					
Birth Date:/ Social Security #: Marital Status: S M D W					
Drivers License Number and State issued State					
Names of Children: Ages:					
Occupation: Employer Name:					
Spouse's Name: Work Phone: ( ) Cell Phone: ( )					
Spouse's Employer: Occupation:					
As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic					
text reminders? [] Yes [] No If yes, who is your cell phone provider?					
ACCIDENT INFORMATION					
Is this visit due to an accident? [] Yes [] No If yes, what type? [] Auto [] Work [] Other Date of Accident					
Has the accident been reported? [] Yes [] No To Whom?Claim Number					
HEALTH INSURANCE INFORMATION					
Name of Your Health Insurance Co					
Policy # Group #					
Insured's Name if different than yours Insured's SS#//					
Relationship to Insured Insured's Birth date/ Employer					
SECONDARY INSURANCE INFORMATION					
Name of Your Health Insurance Co					
Policy # Group #					
Insured's Name if different than yours Insured's SS#/					
Relationship to Insured Insured's Birth date/ Employer					
I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.					
Signature of Patient/or Guardian of said Minor Date					

### **HEALTH HISTORY**

Who is your primary care p	ohysician? (doctor and/or prac	ctice)			
Please check to indicate if	you are currently experien	cing any of the following co	onditions:		
<ul> <li>Neck Pain/Stiffness</li> <li>Back Pain/Stiffness</li> <li>Arm/Hand Pain</li> <li>Leg/Knee Pain</li> <li>Headaches</li> <li>Dizziness</li> <li>Asthma</li> </ul>	<ul> <li>□ Pins/Needles in Arms</li> <li>□ Pins/Needles in Legs</li> <li>□ Fatigue</li> <li>□ Sleeping Difficulties</li> <li>□ Loss of Smell</li> <li>□ Allergies</li> <li>□ Blurred Vision</li> </ul>	☐ Light Bothers Eyes ☐ Depression ☐ Nervousness ☐ Tension ☐ Cold Sweats ☐ Stomach Problems ☐ Night Pain	□ Sudden Weight Loss □ Loss of Taste □ Loss of Memory □ Jaw Problems □ Constipation □ Shortness of Breath □ Bowel/Bladder Changes	<ul> <li>□ Nausea</li> <li>□ Cold Feet</li> <li>□ Chest Pain</li> <li>□ Fever</li> <li>□ Fainting</li> <li>□ Eczema</li> </ul>	
Please check to indicate if	you have ever had any of t	he following:			
☐ Aids/HIV ☐ Alcoholism ☐ Allergy Shots ☐ Anemia ☐ Anorexia ☐ Appendicitis ☐ Arthritis ☐ Asthma ☐ Bleeding Disorders ☐ Breast Lump ☐ Bronchitis ☐ Bulimia ☐ Cancer	☐ Cataracts ☐ Chemical Dependency ☐ Chicken Pox ☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Fractures ☐ Glaucoma ☐ Goiter ☐ Gonorrhea ☐ Gout ☐ Heart Disease ☐ Hepatitis	☐ Hernia☐ ☐ Herniated Disc☐ ☐ Herpes☐ ☐ High Cholesterol☐ ☐ Kidney Disease☐ ☐ Liver Disease☐ ☐ Measles☐ ☐ Migraines☐ ☐ Miscarriage☐ ☐ Mononucleosis☐ ☐ Multiple Sclerosis☐ ☐ Mumps☐ ☐ Osteoporosis☐	☐ Pacemaker ☐ Parkinson's Disease ☐ Pinched Nerve ☐ Pneumonia ☐ Polio ☐ Prostate Problems ☐ Prosthesis ☐ Psychiatric Care ☐ Rheumatoid Arthritis ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Stroke ☐ Suicide Attempt	☐ Thyroid Problems ☐ Tonsillitis ☐ Tuberculosis ☐ Tumors/Growths ☐ Typhoid Fever ☐ Ulcers ☐ Vaginal Infections ☐ Venereal Disease ☐ Whooping Cough ☐ Other	
Are you currently pregnant	? □Yes □No				
Are you currently under drug and/or medical care? □ Yes □ No If yes, explain					
			requency)		
		<del>-</del>			
Please list any surgeries and/or hospitalizations you have had (type & date)					
Please list any supplements you are currently taking (vitamins, minerals, herbs)					
			List Type		
	Procedures in the office sho	ould be avoided if patients l	have certain conditions.		
Please CHECK if you have					
•			ocal or systemic infection		
☐ Corticosteroid or Local Anesthetic Allergy ☐ Additional allergies (please list)					
-	_	•			
	Dia				
		thritis			
			'oga □ Pilates □ Swimmin	g 🗆 Other	
-	stly involve: ☐ Sitting ☐	Standing	☐ Heavy Labor		
What is your daily/weekly	_				
			scups/day Ciga		
I hereby certify that the a to my health.	bove questions were answe	red accurately. I understan	d that providing incorrect in	formation can be dangerous	
Patient's / Guardian's Si	gnature		Date	<u></u>	
Doctor Reviewed Signat	ure		Date	<u>:</u>	
Doctor Updated Signatur	re		Date	<u></u>	

#### RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. By signing below, you give your consent to allow Buckeye Physical Medicine and Rehab – Hilliard and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities. I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial ) Signature of Patient/or Guardian of said Minor \_\_\_\_\_\_ Date \_\_\_\_\_ **AUTHORIZATION OF CARE** This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request. I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees. I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. NAME OF GUARANTOR (person responsible for guaranteeing payment for all services) This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. Patient's Name Printed Date Patient's signature Date Minors Name Guardian/Spouse's Signature of Authorizing care for minor Date I hereby authorize Buckeye Physical Medicine and Rehab - Hilliard to administer care as deemed necessary to my child, a minor under the age of 18 years old. **EMERGENCY CONTACT** Work Phone Name Relationship \_\_\_\_\_ Home Phone Cell Phone

## NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT (CONSENT TO USE PHI)

#### Acknowledgement for Consent to Use and Disclosure of Protected Health Information

#### Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Buckeye Physical Medicine and Rehab - Hilliard or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

#### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

#### Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

#### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### By my signature below, I give my permission to use and disclose my health information as stated in the notice of privacy practices.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date