# 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 _____

# WORK ACCIDENT INFORMATION

Is this visit related to a **work accident** □ Yes □ No **Date of the accident** _____ Claim # _____

MCO Name _____ Phone Number _____

Attorney Name _____ Phone Number _____

Please describe in detail the accident (use the back of this sheet if needed): _____

_____

_____

_____

_____

_____

**Please answer the following questions only if you were injured in an automobile accident at work:**

1. Were you the [] driver [] the passenger [] a pedestrian [] on a bicycle [] on a motorcycle.

2. Were you [] hit (by another vehicle) or [] at fault (you caused the accident)?

3. From which side were you struck [] behind [] the front [] the right side [] the left side [] the right front [] the left front [] the right back [] the left back.

4. At the time of impact were you [] stopped [] moving [] walking [] standing still [] running [] bicycling [] riding a motorcycle [] crossing the street.

5. Were you moving at the time of the accident [] yes or [] no? **If yes**, what was your speed _____?

6. Was the involved party moving when the accident occurred [] yes or [] no, **If yes** what was their speed_____?

7. Did you have your seatbelt on at the time of the accident [] yes [] no?

8. Was your head turned at the time of the accident [] yes or [] no, **If yes** were you looking [] forward [] looking to the right [] looking to left [] looking behind you [] looking up [] looking down.

9. Were you alone at the time of the accident [] yes or [] no? **If no** who was with you _____?

10. What parts of your body hit other structures at the time of impact [] head [] face [] forehead [] back of head [] right TMJ [] left TMJ [] right shoulder [] left shoulder [] right arm [] left arm [] right elbow [] left elbow [] right wrist [] left wrist [] right hand [] left hand [] Right leg [] left leg [] right knee [] left knee [] right ankle [] left ankle [] right foot [] left foot

11. What structures did you hit? [] steering wheel [] windshield [] side window [] door [] roof [] dashboard [] headrest [] seat [] floor [] Side of car [] hood of car [] bumper [] trunk [] the pavement [] tree [] another car [] another person [] another object [] a wall

12. How did you feel after the collision? [] stunned [] disoriented [] lost consciousness [] tightness [] felt mild discomfort [] felt moderate discomfort [] felt severe discomfort [] felt intense pain [] frightened [] felt a popping and ripping sensation [] went to hospital

13. Who was cited for the accident [] me [] other driver

14. Have you had one or more of the following symptoms since your accident? [] Cannot sleep due to the accident [] having trouble getting to sleep since the accident [] Lost time from work due to the accident [] have been depressed since the accident occurred

15. Have you been treated for injuries related to the accident already? [] yes [] no

**If yes**, by whom? _____ Did they perform any diagnostic testing? [] yes [] no

16. Have you lost wages or not been able to work due to the accident? [] yes [] no

# HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

**Please check to indicate if you are currently experiencing any of the following conditions:**

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ 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
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting
- ❑ Eczema

**Please check to indicate if you have ever had any of the 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 _____

Please list any medications you are currently taking (Be sure to include dosage and frequency) _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date) _____

_____

Please list any supplements you are currently taking (vitamins, minerals, herbs)_____

Are you currently on any blood thinners – (aspirin regimen included)? ☐ Yes ☐ No List Type _____

**Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.**

Please CHECK if you have any of the following:

☐ A pacemaker ☐ Suffer from blood clots ☐ Knee/ hip replacement ☐ Local or systemic infection ☐ Egg allergy

☐ Corticosteroid or Local Anesthetic Allergy ☐ Additional allergies (please list) _____

**Is there a family history of any of the following conditions?** (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____ ☐ Other _____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Do you exercise?: ☐ Yes ☐ No How often?: 1X 2X 3X 4X 5X per week Other: _____

Which activities: ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Other _____

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine_____ cups/day Alcohol _____ drinks/week Energy Drinks_____ cups/day Cigarettes_____ packs/day

**I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.**

Patient's / Guardian's Signature_____ Date_____

Doctor Reviewed Signature _____ Date_____

Doctor Updated Signature _____ Date_____

# 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

Name_____ Work Phone_____

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 |