

PATIENT INFORMATION SHEET

PATIENT NAME: _____ DATE OF BIRTH: _____

 SOCIAL SECURITY NUMBER: _____ AGE: _____ SEX: Male Female

 MARITAL STATUS: S M W D EMAIL ADDRESS: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ DAYTIME PHONE: (_____) _____

HOW DID YOU HEAR ABOUT US? Please check all that apply:

Doctor Family Member Friend Google Facebook YouTube PhysicalTherapists.com Healthgrades

REFERRING PHYSICIAN: _____ PHONE: (_____) _____

FAMILY PHYSICIAN: _____ PHONE: (_____) _____

PATIENT'S EMPLOYER: _____ PHONE: (_____) _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POSITION : _____ YEARS ON JOB: _____

 IS INSURANCE UNDER ANOTHER PERSON'S NAME? (Spouse, Parent, Other): Yes No

If yes, NAME OF INSURED: _____

INSURED DATE OF BIRTH: _____ RELATIONSHIP: _____

INSURED'S EMPLOYER: _____ WORK PHONE: (_____) _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF INSURANCE PROVIDER: _____

 VISITS Combined Consecutive Per Condition Per Benefit Period Medicare Cap Medical Necessity

\$ _____ Deductible \$ _____ Deductible Remaining \$ _____ or % _____ Copay

 If your deductible has *not* been met: \$ _____ A portion of your deductible will be collected weekly.

 If your deductible has already *been met*, please initial here: _____

 Do you have any questions regarding your DEDUCTIBLE or CO-INSURANCE? Yes No

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Due to constantly changing insurance regulations, benefits, and deductibles, we are only able to approximate your insurance benefits. If your insurance pays more than expected, you will be credited the difference. If your insurance company pays less than expected, you will be charged for the difference. Final responsibility for payment rests with the person responsible for your account.

Upon admission to our facility, it is very important that you, the patient, inform us, the provider, regarding the circumstances surrounding your injury. In certain instances, an insurance company may recoup its' payment for information withheld from the providers or the patients.

If applicable, have you given the office staff any litigation details and/or attorney information, necessary to process your claim?

____ YES ____ NO If no, please explain: _____

Attorney Name/Address/Phone: _____

Court/Case Number: _____

The insurance benefit information listed on page one is the expected eligible coverage for your insurance contract and we will process your insurance claim. You must realize that your insurance coverage is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We are legally required to charge for deductibles and copays that apply to your contract. These charges are your responsibility. If necessary, please contact us promptly for assistance in the management of your account.

- I hereby authorize direct payment of benefits otherwise payable to me, to David Gilboe and Associates, P.C. I understand that I am financially responsible to David Gilboe and Associates, P.C. and my Physical Therapist for charges not covered by this agreement.
- I understand that I am obligated to pay all co-payments at the time agreed upon by David Gilboe and Associates, P.C. and myself.
- I authorize any holder of medical or other information about me to release such information as necessary to process these claims or related medical claims.
- I permit a copy of this authorization to be used in place of the original.

As part of our therapeutic relationship, we strive to use progressive communication tools such as email and SMS texting to keep you informed and connected with us. Our services include sending you a monthly email newsletter and spontaneous tips for your wellness. *We do not send personal information in our communications.*

Most messages are sent through email and occasionally through SMS texting. For email communications, you may choose to unsubscribe at any time to our newsletters and tips, and a link to unsubscribe is provided with every communication. For SMS texting, click the link to our communication and the option to unsubscribe is visible at the bottom of your screen. We understand that some phone carriers have text messaging fees and we are not responsible for these costs. *Your email address and phone number are never shared with anyone and we keep your information strictly private.*

Pursuant to Title VI, Section 504 of the Rehabilitation Act of 1973, it is the policy of David Gilboe and Associates, P.C., to employ, admit and treat all persons without regard to race, color, national origin, handicap, contagious disease or age.

By signing this form, you acknowledge that you have been informed of our privacy practices and procedures for the use and disclosure of your protected health information.

I have received and read this agreement and declare that the information is true to the best of my knowledge and belief. I understand and agree to all of the terms.

Patient Signature (if minor, parent or guardian) Date

Witness Signature (David Gilboe and Associates, P.C.) Date

PATIENT HISTORY FORM

Instructions: Please fill out as complete as possible. All information will be kept confidential.

PATIENT NAME: _____ Height _____ Weight _____

A. CURRENT MEDICATIONS (name only): _____

☐ See attached list

B. HEALTH HISTORY:

1. ILLNESS / MEDICAL PROBLEM:

Please put an X by any of the following conditions you have/had and give an approximate year that they started.

Use the lines below for any additional comments or explanations.

ILLNESS	X	YEAR	EXPLANATION
High Blood Pressure	<input type="checkbox"/>	_____	_____
Heart Attack	<input type="checkbox"/>	_____	_____
Chest pain	<input type="checkbox"/>	_____	_____
Congestive Hrt Failure	<input type="checkbox"/>	_____	_____
Blood Clot	<input type="checkbox"/>	_____	_____
Irregular hrt beat	<input type="checkbox"/>	_____	_____
Mitral valve prolapse	<input type="checkbox"/>	_____	_____
Other heart conditions	<input type="checkbox"/>	_____	_____
Emphysema	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	_____	_____
Shortness of breath	<input type="checkbox"/>	_____	_____
HIV	<input type="checkbox"/>	_____	_____
Cancer or tumor	<input type="checkbox"/>	_____	_____
Stomach/GI condition	<input type="checkbox"/>	_____	_____
Liver trouble	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	_____	_____
Hernia	<input type="checkbox"/>	_____	_____
Kidney or bladder disease	<input type="checkbox"/>	_____	_____
Prostate problem	<input type="checkbox"/>	_____	_____
Headaches	<input type="checkbox"/>	_____	_____
Dizziness	<input type="checkbox"/>	_____	_____
Seizures	<input type="checkbox"/>	_____	_____
Thyroid disease	<input type="checkbox"/>	_____	_____
Head injury	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	_____	_____
Bleeding tendency	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	_____	_____
Skin conditions	<input type="checkbox"/>	_____	_____
Mental illness/depression	<input type="checkbox"/>	_____	_____
Broken bones	<input type="checkbox"/>	_____	_____
Joint sprains	<input type="checkbox"/>	_____	_____
Eye/vision problems	<input type="checkbox"/>	_____	_____
Hearing loss	<input type="checkbox"/>	_____	_____
Allergies	<input type="checkbox"/>	_____	_____
Other	<input type="checkbox"/>	_____	_____

2. SURGERIES: ☐ Gall Bladder ☐ Tonsils ☐ Appendix ☐ Hysterectomy
☐ Hernia ☐ C-Section ☐ Coronary Bypass ☐ Thyroidectomy
☐ Neck surgery ☐ Back surgery ☐ Carpal tunnel ☐ Cataract

3. Other Surgeries: _____

Do you have anything artificial in your body? List: _____

3. SPECIAL TESTS: (relating to current complaint) Xrays EMG Doppler MRI Arthogram
CAT scan Bone Scan Other: _____

C. SOCIAL / PERSONAL HISTORY:

Currently live: ☐ Alone ☐ With parents ☐ With siblings ☐ With spouse ☐ With children Ages? _____
☐ With friends ☐ With significant other

Type of dwelling: House ☐ one-story ☐ two-story ☐ three-story
Apartment ☐ 1st floor ☐ 2nd floor ☐ other _____
Other _____

Laundry: ☐ basement ☐ 1st floor ☐ 2nd floor ☐ Laundry mat

How many stairs does it take to enter your home? _____

Have you experienced any falls within the past six months? ☐ Yes ☐ No

If yes, describe circumstance: _____

Do you have relatives / friends who can help you with your care? ☐ No ☐ Yes Who? _____

Do you have relatives / friends who are dependent on you for care? ☐ No ☐ Yes Who? _____

Do you exercise regularly? ☐ No ☐ Yes How often? _____

Type of exercise: _____

Were you involved in sports prior to your current complaint? ☐ No ☐ Yes What type? _____

Has your current complaint limited your participation in exercise or sports? ☐ No ☐ Yes

Do you have any hobbies? ☐ No ☐ Yes Describe: _____

Do you smoke? ☐ No ☐ Yes How much? _____

Are you currently employed? ☐ No ☐ Yes

If yes, describe the activities involved with your job (i.e. sitting, standing) _____

Signature of person filling out form: _____ Date _____

OFFICE USE ONLY (Below)

I have reviewed the Patient History Form as provided.

Therapist Signature: _____

Date _____