LAKE OCONEE
REHABILITATION
PHYSICAL THERAPY

PATIENT INFORMATION SHEET
RETURNING PATIENT

Patient Name: ________________________ **Date of Birth:** ____________________

*Is this visit due to a work injury or auto accident? Y☐ N☐ If 'NO', skip section and go to **Payment Information**

Employer Name: ______________ Occupation: ________________ Phone: ____________

Accident/Injury Date: ______________ Do you have an attorney for this accident or injury? Y☐ N☐

Attorney's Name & Contact Number: ________________________________

PAYMENT INFORMATION (check ONE of the following boxes)

☐ **CASH PAYER / I DO NOT** have insurance. I will pay out of pocket with cash, check, or credit card for services. A $35.00 fee will be charged to my account for returned checks and may result in LORPT asking for a different form of payment.

☐ **INSURANCE / I HAVE** insurance. LORPT will file all claims to insurance. I understand that I am financially responsible for any non-covered service(s), copays, coinsurance, deductibles, etc. It is my responsibility to understand my insurance policy and to notify this practice of any changes to my policy and/or coverage.

Primary Insurance: ________________________ Are you the primary policy holder? Y☐ N☐

Policy#: ________________________________ Group#: ________________

Secondary Insurance: ________________________ Are you the primary policy holder? Y☐ N☐

Policy#: ________________________________ Group#: ________________

Have you had PT this year? Y☐ N☐ If yes, where? ________________________

Do you live in a Nursing Home? Y☐ N☐ If yes, where? ________________________

Are you covered under Black Lung Disease? Y☐ N☐

Are you covered under End Stage Renal Disease? Y☐ N☐

Do you receive Home Health Services? Y☐ N☐

PRIVACY, RIGHTS, & POLICY ACKNOWLEDGEMENT

As a returning patient, I acknowledge that I have received a copy of the following Lake Oconee Rehabilitation Physical Therapy notices, rights, and policies: 1) Privacy Notice / Patient Rights
2) Cancellation/No Show Policies

The above information has been reviewed and I have been "given the opportunity" to have questions answered to my satisfaction. I understand that if I need a new copy of the items listed above, they can be requested through the Lake Oconee Rehabilitation Physical Therapy front office at any time.

______________________________ ______________

Patient / Responsible Party Signature Date

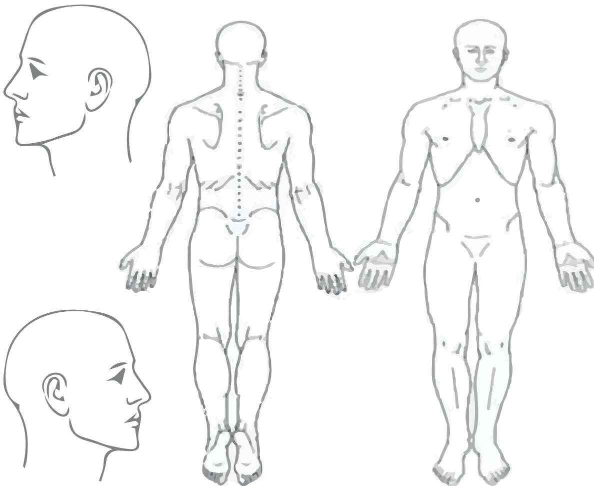
LAKE OCONEE
REHABILITATION
PHYSICAL THERAPY

PATIENT INFORMATION SHEET
NEW PATIENT

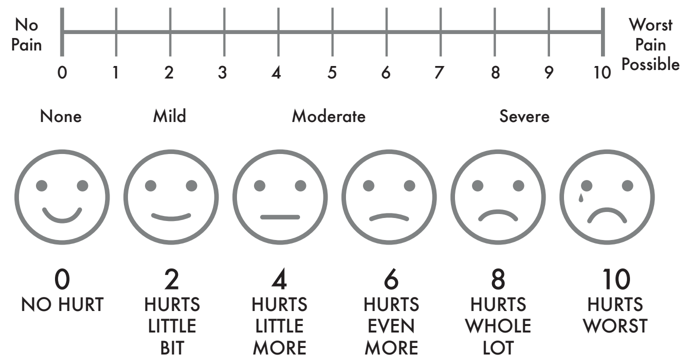
Do you have any of these conditions?

Condition		
Allergies	Yes	No
Anemia	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Cardiac Conditions	Yes	No
Cardiac Pacemaker	Yes	No
Chemical Dependency	Yes	No
Circulation Problems	Yes	No
Currently Pregnant	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Dizzy Spells	Yes	No
Emphysema / Bronchitis	Yes	No
Fractures	Yes	No
Falls	Yes	No
2 or more Falls in past year	Yes	No
Gallbladder Problems	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
Incontinence	Yes	No
Kidney Problems	Yes	No
Metal Implants	Yes	No
Multiple Sclerosis	Yes	No
Osteoporosis	Yes	No
Parkinson's	Yes	No
Rheumatoid Arthritis	Yes	No
Seizures	Yes	No
Speech Problems	Yes	No
Strokes	Yes	No
Thyroid Disease	Yes	No
Tuberculosis	Yes	No
Vision Problems	Yes	No

Please circle the locations of your pain



Pain Rating Scale



Other conditions the physical therapist should know about that are not listed above? If 'yes', please provide:

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117 HARMONY CROSSING, SUITE 4, EATONTON, GA 31024
PHONE – (706) 454-1811 FAX - (706) 454-1812

1000 COWLES CLINIC WAY, SUITE D-100, GREENSBORO, GA 30642
PHONE – (706) 454-1394 FAX - (706) 454-1397

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MEDICATION LIST

Patient Name: ______________________________

PRESCRIPTION MEDS:

MEDICATION	DOSAGE	MEDICATION	DOSAGE

NON-PRESCRIPTION MEDS:

MEDICATION	DOSAGE

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