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? _____

PRIVACY, RIGHTS, & POLICY ACKNOWLEDGEMENT

As a returning patient, I acknowledge that I have received a copy of Rehabilitation and Performance Center's following notices, rights, and policies: 1) Privacy Notice / Patient Rights
2) Hipaa Privacy Policy
3) Cancellation / No Show Policies.

The above information has been reviewed and I have been given 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 Rehabilitation and Performance Center's front office at any time.

_____ _____

Patient / Responsible Party Signature Date

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PATIENT INFORMATION SHEET
RETURNING PATIENT - MEDICAL HISTORY 1/2

Legal Name: _____ Gender: M F Age: _____

Leisure Activities: _____ Height: _____ Weight: _____

Referring Doctor: _____ Returning appointment date: _____

Relation to Patient: _____

Currently seen by: ☐ Medical Doctor ☐ Psychiatrist/Psychologist ☐ Dentist ☐ Physical Therapist ☐ Chiropractor ☐ Osteopath

Onset of current injury/symptoms (date): _____

Have you had surgery as a result of your current injury? Y ☐ N ☐ If yes, date of surgery: _____

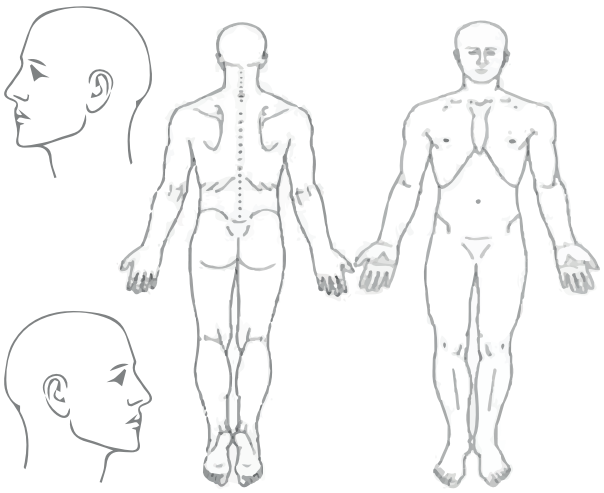
Have you had physical therapy for the current injury/symptoms? Y ☐ N ☐

Do you have an attorney for this accident or injury? Y ☐ N ☐

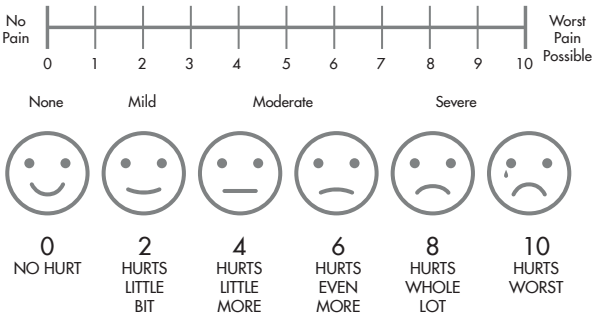
Describe current injury / symptoms: _____

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

Paient Legal Name: _____ Date: _____

Allergies: ☐ None List allergies here: _____

_____

CURRENT PRESCRIBED MEDICATIONS:

Medication Name	Reason taken	Dose	Frequency	Route

SURGICAL HISTORY:

Body Region	Surgery Type	Date / Year of surgery

Your signature acknowledges that all information given is accurate and truthful to the best of your knowledge.

_____ _____

Patient / Responsible Party Signature Date