BARREN RIDGE PHYSICAL THERAPYPATIENT DATA SHEET				
First:	MI:	Last:		
Date of Birth:	Age:	Gender: Male Female		
Physical Address:		Mailing Address:		
Phone Numbers: OK To	Call Best Tin	ne To Call		
Home:				
Work:				
Cell:				
May we send you text message above? Yes No	s for your appo	ointment reminders to the number(s) listed		
May we send you text message the number(s) listed above?	es for Marketing Yes No	Materials, including Patient review requests to		
By marking "Yes" above, you use of unauthorized access to your		text messages may NOT be secure, with a risk		
May we send you emails relating By providing your email address may NOT be secure, with a risk Email:	ss below, you u	nderstand that email communications		
Preferred language:		Interpreter required?		
Date of Injury:	Refer	ring Physician:		
Injury Area:		Work Accident: Auto Work N/A		
State Where Accident Occured	:			
Are you currently receiving or h (including any therapy, nursing,	•	1 1 100 1 110		
Are you currently receiving or h the last 60 days?	ave you receive	ed other therapy services in Yes No		
Marital Status:				
Married Single I	Divorced \[\]	Widowed Separated Unknown		
Student Status:				
Full-Time Part-Time	None			

Patient Name:						Pa	ge: 2/
EMPLOYMENT STATUS							
Employme Active		Full-Time	None	Part-Time	Retired	Self Employe	ed
Employer:				Occupation:			
Address:							
Phone:							
Employer:				Occupation:			
Address:							
Phone:							
INSURANCE INFORMATION							
Primary Ins	surance:						
Policy Hold	der's Name:			Holder's	Birth Date:		
Policy or C	ertificate #:				Group #:		
Policy Holo	ler's Employ	/er:					
Policy or C	ertificate #:				Group #:		
Policy Hold	der's Employ	yer:					

MR #: Page: 3/4 Patient Name: How did you hear about us? **Physician** Hospital Marketing Ad - Print **Employer Cross Referral** Friend - Word of Mouth Case Manager ■ Marketing Ad - Billboard Former Patient Marketing Ad - Direct Mail - Email Attorney Adjustor Self School **Screens - Open Houses** Marketing Ad - Other ____ Specify if other: Note: Please provide us with the most updated information below. **EMERGENCY AND OTHER CONTACTS** Name Phone Work Cell Fax Туре DISCLOSURE OF MEDICAL RECORDS I authorize the following individuals to have access to my medical and billing records: Relationship Name Relationship Name

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

A/C# Name A/C Type Office # Internal Use Only: CONSENT TO TREATMENT I consent to rehabilitation and related services at: BARREN RIDGE PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: TREATMENT OF MINORS I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: LIABILITY I know and agree that:BARREN RIDGE PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. **WAIVER AND RELEASE** I hereby release, discharge and acquit: BARREN RIDGE PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: **AUTHORIZATION OF PAYMENT** I hereby assign all benefits directly to: BARREN RIDGE PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: FINANCIAL POLICY I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please: - Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. - Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. - Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initials: NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS I acknowledge receipt of Notice of Privacy Practices. Initials: I acknowledge receipt of the Statement of Patient Rights. Initials: I certify that all of the information provided herein is true and correct. Patient/Guardian Witness Signature Signature _

Medical History Form

Patient Name:		Today's Date:			
Referring Physician:		Date of Birth: Age:		Age:	
Primary Care Physician:	re Physician: Date of Injury or Onset:				
Date of Next Physician Appointment:					
Reason for Therapy:		I			
Course of Indiana on Operate Assistant	Ata D. Marile D. Otha	If Other relea	aa avulain.		
Cause of Injury or Onset: ☐ Accident ☐	Auto Work Othe	r: If Other, plea	ise explain:		
Have you been hospitalized for the present condition? Yes No If Yes, date:					
Did you have surgery for this condition If Yes, surgery type:	? 🗌 Yes 🗌 No	If Yes, date:			
Are you currently receiving any other call f Yes, please describe:	are for the condition r	nentioned above?	□Yes □No		
Have you ever received therapy in the p	past for the condition	mentioned above? [_Yes	es, date:	
Describe previous treatment:					
Previous Treatment: ☐Successful ☐Un	successful				
Have you fallen in the last year? ☐ Yes ☐ No If Yes, how many times? If Yes, were you injured? ☐ Yes ☐ No Do you worry about falling? ☐ Yes ☐ No					
What are your personal goals/outcome	s you hope to achieve	from therapy?			
Describe your general health: Excel	lent ☐ Good ☐ Fair	☐ Poor Do yo	ou smoke or use	tobacco?	
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)					
☐ Allergies ☐ Latex ☐ Other	☐ Dizziness		☐ Kidney Problems		
☐ Anemia	☐ Epilepsy or Seizure Disorder		☐ Metal Implants		
☐ Anxiety or Panic Disorders	☐ Fainting		☐ MRSA		
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness		☐ Multiple Sclerosis		
☐ Asthma	☐ Fever or Chills		☐ Nausea / Vomiting		
☐ Use of Blood Thinners	☐ Fractures		☐ Osteoporosis		
☐ Bowel or Bladder Disorder	☐ Headaches		☐ Pacemaker		
☐ Bleeding Disorder	☐ Head Injury or Concussion		☐ Parkinson's Disease		
☐ Cancer	☐ Hearing Impairment		☐ Peripheral Vascular Disease		
☐ Chronic Cough	☐ Heart Disease or Heart Attack		☐ Respiratory or Breathing Problems		
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C		☐ Ringing in Ears		
☐ Congestive Heart Failure	☐ Hernia		☐ Sexual Dysfunction		
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low		☐ Skin Abnormalities		
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS		☐ Stroke or TIA		
☐ Depression	☐ Hypoglycemia		☐ Thyroid Problems		
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity	Hypersensitivity to Hot or Cold		sis	
List any other medical problems and explain:					

Medical History Form

Medication List					
Name of Medication	Dosage	Frequency			
☐ Check Box if Medication List provided separately.					
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
4.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
5.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
6.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
8.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
9.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
11.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
12.			☐ Injection ☐ Oral ☐ Topical ☐ Other		
Over the Counter Medications (check all that apply): Aspirin/Ibuprofen Antacids Sleeping Aids Cold Medicine: Cough Medicine Allergy Relief Laxative Diet Pills Vitamins/Herbal Supplements Other:					
Pain Scale Rate the severity of your pain by circling a box on the following scale. No Pain Worst Pain 1 2 3 4 5 6 7 8 9 10 On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location. KEY: A = Aching B = Burning N = Numbness P = Tingling S = Stabbing O = Other					
Signature of Patient:		DOB:			
Printed Name of Patient:		Date:			