Physical Therapy Center Chesapeake

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

Name:_____ Date of Birth:_____ Age:_____ Appt Date: _____

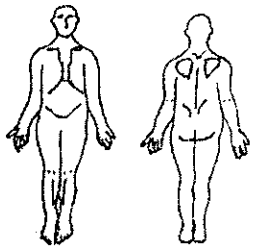
Please describe the onset of your injury and/or pain for which you are seeking treatment:

_____

_____

Circle area that applies

Date of Surgery: _____



Circle systoms that apply

Aching pain throbbing tingling

Sharp pain dull pain stiffness

Burning numbness

Severity of pain (scale of 0 – 10)

Best – 0 1 2 3 4 5 6 7 8 9 10

Worst – 0 1 2 3 4 5 6 7 8 9 10

Medical information: please check all that apply

___heart disease ___high blood pressure ___cancer ___are you pregnant

___diabetes ___asthma ___fainting Are you latex sensitive? YES NO

___pacemaker ___RA/RO ___seizures ___other:_____

Have you had 2 or more falls or any falls with injury in the past year? YES NO

Release of Medical Information

This notice confirms that I, _____, authorize Physical Therapy Center of Chesapeake and staff to release all medical information to:

_____ _____

Referring Physician Family Physician/Internist

_____ _____

Spouse/Guardian Other

You may revoke or terminate this authorization by submitting a written revocation to Physical Therapy Center of Chesapeake.

_____

Patient's Name

_____ _____

Signature of Patient or Guardian Date

Medication List for:
Date:

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

Patient Signature: ______________________________ Date: ________________________

Reviewed by: __________________________________ Date: ________________________

PHYSICAL THERAPY CENTER OF CHESAPEAKE
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COVID-19 Screening

Please answer YES or NO to the following questions:

1. Within the last 14 days have you experienced a new cough?
2. Within the last 14 days have you experienced new shortness of breath?
3. Within the last 14 days have you had a temperature at or above 100.4?
4. Within the last 14 days have you experienced a new sore throat?
5. Within the last 14 days have you experienced new muscle aches not specific to activity such as physical exercise?
6. Within the last 14 days have you had close contact with or cared for someone diagnosed with COVID-19?
7. Within the last 14 days have you traveled to or from any other countries?

*If at any time in the course of your treatment you experience any of the above symptoms please notify our office before your next appointment.

_____ _____

Signature Date

COVID-19 Medical Treatment Consent Form

I consent to receive medical treatment from Physical Therapy Center of Chesapeake, LLC during the COVID-19 outbreak. I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted. I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions form someone with COVID-19. I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the treatments and/or procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice. I confirm I am seeking what I believe to be necessary treatment because of underlying conditions that limit my normal day-to-day activities. _____ (Patient initial)

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry cough
- Shortness of breath
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: _____ (Patient initial). I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____ (Patient initial). I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____ (Patient initial).

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____