

Dynamic Physical Therapy Demographic Form

Full Name: _____ Preferred Name: _____

Birth Date: _____ Gender: ☐ male ☐ female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Phone: _____ Name/Relationship to you: _____

Occupation: _____ Employer: _____

Work Phone: _____ Employment Status: _____

Social Security Number (for billing your insurance) _____

Email Address: _____

****By giving us your email address, you are joining the Dynamic Physical Therapy community and will get the latest communications on healthcare and other relevant physical therapy information. You can unsubscribe at any time and we will NOT share your information with outside parties.**

Name of physician who referred you: _____

How did you hear about Dynamic Physical Therapy?

____ Friend ____ Returning Patient ____ Physician ____ Phone Book
____ Email ____ Internet/Website ____ Other, Please Explain _____

Are you seeing us for a work injury or auto accident injury: ☐ yes ☐ no

→ If yes, we will ask you for specifics after you return this form.

Medicare patients only:

→ Are you currently receiving any services from a home health agency (nursing, aide, therapy, speech, any in-home assistance)? ☐ yes ☐ no

Primary insurance company: _____

Policy holder's name & date of birth: _____

Secondary insurance company: _____

Policy holder's name & date of birth: _____

Please describe what we are seeing you for today: _____

**Dynamic Physical Therapy
Medical History Form**

<u>Do you have heart or blood vessel problems?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have diabetes?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have lung or airway problems?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have kidney or liver disease?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have balance problems?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Are you depressed?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have persistent joint or muscle pain?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Are you sleeping well?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you exercise weekly?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have bowel or bladder problems?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have an autoimmune disease?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have cancer?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have a neurological condition?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Have you had surgery recently?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have vision or hearing loss?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have loss of feeling anywhere on your body?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Are you seeing other medical providers at this time?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have allergies?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you smoke ?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have osteoporosis?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Have you been diagnosed with arthritis?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Are you pregnant?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have shortness of breath?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Do you have a pacemaker or other implants?</u>	☐ <u>yes</u>	☐ <u>no</u>
<u>Are you taking medication?</u>	☐ <u>yes</u>	☐ <u>no</u>

Please list your medication(s) below or provide your own list:

Please add any additional medical history or other things you'd like us to know:

Patient Name: _____

Signature: _____

Date: _____

PT initials:

Dynamic Physical Therapy Consent Form

Patient Name: _____

Consent to evaluate and treat.

Initials:

I consent to physical therapy services at Dynamic Physical Therapy. I understand that if I have any questions or concerns about my care I should ask my therapist. I know it is up to me to inform the physical therapist about any health problems, diseases, illnesses or allergies I have. I must also tell the physical therapist about drugs/medications I am taking, if I have a pacemaker/metal implants or if I am pregnant.

Consent to contact and bill insurance.

Initials:

I authorize Dynamic Physical Therapy to work with my insurance company to determine my coverage for physical therapy. I understand it is my responsibility as a patient to know my insurance coverage. I permit Dynamic Physical Therapy to bill and receive payments from my insurance company directly. I understand that I am responsible for co-payments and deductibles as dictated by my insurance policy. I also may be responsible to pay for charges my insurance company considers "non payable" treatment codes.

Consent to release personal health information.

Initials:

I give permission to Dynamic Physical Therapy to release my personal health information to obtain payment for provided services. I also allow the release of personal health information to my physician and other professionals who take part in my care. I have been provided with a copy of Dynamic Physical Therapy's Privacy Notice.

Patient signature: _____

Date: _____

Signature of patient representative: _____

Relationship to patient: _____

Date: _____

Dynamic Physical Therapy
8872 Professional Drive, Suite C
Cadillac, MI 49601
Phone – 231-876-0010
Fax – 231-876-0241

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to: **(1)** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly. **(2)** Obtain payment from third party payers. **(3)** Conduct normal healthcare operations such as quality assessments and physician certifications.

Please provide us with some helpful information regarding whom we may release your information to or contact.

My Medical Information May Be Released To:

Name_____

Relationship to Patient _____ Phone#_____

Name_____

Relationship to Patient _____ Phone#_____

Home Contact:

Ok to leave message with detailed information? Yes No

Leave a message with our call back number only? Yes No

Work Contact:

Ok to leave a message with detailed information? Yes No

Leave message with our call back number only? Yes No

Written Communication:

Ok to mail information to your home? Yes No