

# Patient Intake Form

## Patient Information

Name: \_\_\_\_\_ Gender: Male Female  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Mobile/Pager Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_  
 Employment Status: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employers Name: \_\_\_\_\_ Employers Phone: \_\_\_\_\_

### Emergency Contacts

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please tell us who your other providers are:** and, may we have permission to contact them: Y N  
 Cardiologist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 OBGYN: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Other: \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Insurance Information

Insurance Company Name: \_\_\_\_\_  
 Type of Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Subscribers Name: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Subscribers Employer: \_\_\_\_\_  
 Subscribers SSN: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_  
 Customer Service Phone Number (Located on back of insurance card): \_\_\_\_\_

### Secondary Insurance Information

Insurance Company Name: \_\_\_\_\_  
 Type of Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Subscribers Name: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Subscribers Employer: \_\_\_\_\_  
 Subscribers SSN: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_  
 Customer Service Phone Number (Located on back of insurance card): \_\_\_\_\_

*If your injury is related to work or an auto accident, please provide our office with the details of your insurance coverage for this incident.*

# Patient History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

General Instructions: Indicate Yes or No for each item below. If Yes, indicate your age when it occurred.

Yes/No Age	Yes/No Age	Yes/No Age
_____ Arthritis/Rheumatism	_____ Asthma/Wheezing	_____ Emotional Problems
_____ Broken Bones	_____ Pneumonia/Pleurisy	_____ Alcohol/Drug Addictions
_____ Dislocated Joints	_____ Tuberculosis	_____ Neuritis/Pinched Nerves
_____ Painful/Stiff Joints	_____ Chronic Cough	_____ Polio or Paralysis
_____ Elbow/Shoulder Trouble	_____ Phlegm or Spitting Blood	_____ Kidney Disease or Stones
_____ Knee Trouble	_____ Breathing Difficulties	_____ Blood Disease or Anemia
_____ Foot Trouble	_____ Swelling of Ankles	_____ Cancer, Tumor or Growths
_____ Head, Neck or Spinal Injuries	_____ Chest Pain or Pressure	_____ Jaundice or Hepatitis
_____ Back Trouble	_____ Rheumatic or Scarlet Fever	_____ Stomach Trouble or Ulcer
_____ Eye Trouble or Injury	_____ Heart Trouble or Murmur	_____ Hemorrhoids or Rectal Disease
_____ Hay Fever or Allergy	_____ High Blood Pressure	_____ Hernia (Rupture)
_____ Hives, Eczema or Skin Trouble	_____ Epilepsy, Fits or Convulsions	_____ Diabetes
_____ Sinus Trouble	_____ Frequent or Severe Headaches	_____ Varicose Veins
_____ Chronic Ear Infections	_____ Dizziness or Fainting	_____ Hearing Difficulty

General Instructions: Check Yes or No column for the following items. If Yes, please explain.

Yes	No	
_____	_____	Have you ever had any serious ill effects from activities you have done? _____
_____	_____	Has your activity ever had to be limited or restricted on account of your health? _____
_____	_____	Have you ever been a patient in a hospital? _____
_____	_____	Do you have any condition, which may require limits to your daily activities? _____
_____	_____	Have you ever had any surgical operation, or been advised to have one? _____
_____	_____	Have you ever had an injury or ailment to your neck and/or back? _____
_____	_____	Have you ever had an injury or operation to either knee or shoulder? _____

Do you now (as of 1 month ago) smoke cigarettes? YES \_\_\_\_\_ NO \_\_\_\_\_

How many years have you smoked (did smoke) cigarettes? \_\_\_\_\_

Are you taking medication? Please list. \_\_\_\_\_

WOMEN: Are you pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_

I, \_\_\_\_\_, (DOB \_\_\_\_\_) hereby request and consent to the performance of therapy, including examination and diagnosis, on me by Arizona Orthopedic Physical Therapy, PLLC and other physical therapists and occupational therapists under Arizona Orthopedic Physical Therapy, PLLC supervision. I consent to the treatment plan and intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physical Therapist Signature (Reviewed by) \_\_\_\_\_

### **Financial Policy**

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

We will request a photocopy of the front and back of your insurance identification card and driver's license. Please update your card with any additional information your insurance company provides, which will facilitate the submission of claims on your behalf. It is your responsibility to inform us of any changes to your policy. We will bill your insurance company on your behalf as a courtesy.

**Co-Payments:** We must collect your carrier-designated co-pay at the time of service. Refusal to abide by this agreement may result in termination of your coverage.

**Missed Appointments:** Patients who do not show up for an appointment, and do not call to cancel have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patients' insurance contract, we reserve the right to charge a \$20.00 fee for missed appointments.

**Bounced Checks:** If a check is used as your form of payment, and that check is returned for insufficient funds or payment has been stopped, you will be charged a \$25.00 fee in addition to the amount of the check.

### **Insurance**

We will gladly bill and accept payment from your health insurance plan. Your co-payment or deductible is due and payable at the time of service. We accept cash, checks, Mastercard and Visa. Any amounts not covered by your insurance carrier are your responsibility.

### **Payments**

You are responsible for any amount not covered by your insurance carrier. All co-payments and deductible amounts are due at the time of service.

We find communication between our office and our patients help us to succeed in providing the best care. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

### **Patient or Guarantor**

I have read and understand the above. I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Arizona Orthopedic Physical Therapy, PLLC. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments and deductibles.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



## Authorization for the Release of Medical Records

I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to release the medical record(s) of:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

for the purpose of continued treatment and billing/re-assignment of benefits (allows AZ-OPT to bill on your behalf, and for the payment to be sent directly to AZ-OPT) to:

Arizona Orthopedic Physical Therapy, PLLC.  
14535 W. Indian School Rd.  
Suite 100  
Goodyear, AZ 85338  
Phone: 623-242-6908  
Fax: 623-242-2909

Signature of Patient or Patient's Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of Personal Representative (if any): \_\_\_\_\_

Representative's Authority to Act for Patient: \_\_\_\_\_

## Notice of Privacy Practices

Your name and signature on this cover sheet indicate that you have received a copy of and/or have been directed to the poster displayed in the clinic lobby of Arizona Orthopedic Physical Therapy, PLLC (AZ-OPT's) Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information set forth in AZ-OPT's Notice of Privacy Practices, please do not hesitate to ask at the desk or the physical therapist.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date and Time Notice Received: \_\_\_\_\_