

PATIENT INTAKE FORM

Please complete ALL sections.

PERSONAL INFORMATION

LAST NAME		MIDDLE INITIAL	FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN	
ADDRESS STREET	CITY		STATE	ZIP
PHONE NUMBERS <input type="checkbox"/> HOME	<input type="checkbox"/> WORK		<input type="checkbox"/> CELL	
<i>Please check the phone number at which messages should be left for you.</i>				
EMAIL ADDRESS				
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor				
EMPLOYER'S NAME			OCCUPATION	

EMERGENCY CONTACT

LAST NAME		FIRST NAME	
RELATIONSHIP		PHONE NUMBER	

REFERRAL

PRIMARY PHYSICIAN	PHONE NUMBER
REFERRING PHYSICIAN	PHONE NUMBER
SOURCE OF REFERRAL <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Doctor <input type="checkbox"/> Insurance <input type="checkbox"/> Online (Google / Bing / Yahoo / Yelp / Other _____) <i>If ONLINE, please circle one or more sources that is appropriate.</i>	

Please submit ALL Insurance cards and your Photo I.D. to the Receptionist. If you do not have Insurance, you will be required to pay at the time of service. If your Insurance requires a referral and you do not have one at the time of service, you will be required to pay for the charges incurred. **All the information provided by me in the intake forms is accurate and correct to the best of my knowledge.**

PATIENT'S SIGNATURE (SPOUSE, OR PARENT/GUARDIAN IF PATIENT IS UNDER 18)	DATE (MM/DD/YYYY)
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HEALTH HISTORY FORM

It is important to gather information about your medical history in order to provide you with the highest quality care. Please fill out this form to the best of your knowledge. Thank you!

Please check the boxes when appropriate.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES/CONDITIONS?

HEART ATTACK/STROKE	<input type="checkbox"/> Y <input type="checkbox"/> N	FREQUENT NECK PAIN	<input type="checkbox"/> Y <input type="checkbox"/> N	HEPATITIS	<input type="checkbox"/> Y <input type="checkbox"/> N
HEART SURGERY/PACEMAKER	<input type="checkbox"/> Y <input type="checkbox"/> N	EMPHYSEMA/GLAUCOMA	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV AND/OR AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
HEART MURMUR	<input type="checkbox"/> Y <input type="checkbox"/> N	ANEMIA	<input type="checkbox"/> Y <input type="checkbox"/> N	SHINGLES	<input type="checkbox"/> Y <input type="checkbox"/> N
CONGENITAL HEART DEFECT	<input type="checkbox"/> Y <input type="checkbox"/> N	HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/> Y <input type="checkbox"/> N	CANCER	<input type="checkbox"/> Y <input type="checkbox"/> N
MITRAL VALVE PROLAPSE	<input type="checkbox"/> Y <input type="checkbox"/> N	PSYCHIATRIC PROBLEMS	<input type="checkbox"/> Y <input type="checkbox"/> N	CHEMOTHERAPY	<input type="checkbox"/> Y <input type="checkbox"/> N
ARTIFICIAL VALVES	<input type="checkbox"/> Y <input type="checkbox"/> N	RHEUMATIC FEVER	<input type="checkbox"/> Y <input type="checkbox"/> N	ULCERS/COLITIS	<input type="checkbox"/> Y <input type="checkbox"/> N
ALCOHOL/DRUG ABUSE	<input type="checkbox"/> Y <input type="checkbox"/> N	SEVERE/FREQUENT HEADACHES	<input type="checkbox"/> Y <input type="checkbox"/> N	ASTHMA	<input type="checkbox"/> Y <input type="checkbox"/> N
VENEREAL DISEASE	<input type="checkbox"/> Y <input type="checkbox"/> N	KIDNEY PROBLEMS	<input type="checkbox"/> Y <input type="checkbox"/> N	DIFFICULTY BREATHING	<input type="checkbox"/> Y <input type="checkbox"/> N
SINUS PROBLEMS	<input type="checkbox"/> Y <input type="checkbox"/> N	FAINING/SEIZURES/ EPILEPSY	<input type="checkbox"/> Y <input type="checkbox"/> N	ARTIFICIAL JOINTS	<input type="checkbox"/> Y <input type="checkbox"/> N
TUBERCULOSIS	<input type="checkbox"/> Y <input type="checkbox"/> N	LOWER BACK PROBLEMS	<input type="checkbox"/> Y <input type="checkbox"/> N	DIABETES (IF YES, <input type="checkbox"/> TYPE I <input type="checkbox"/> TYPE II)	<input type="checkbox"/> Y <input type="checkbox"/> N

OTHER

FAMILY HEALTH HISTORY

LIST ANY ALLERGIES

LIST ANY PREVIOUS SURGERIES AND/OR INJURIES TYPE	DATE (MM/DD/YYYY)

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS

Excellent Very Good Good Fair Poor

ARE YOU TAKING ANY MEDICATIONS?

Yes No

IF YES, PLEASE LIST WHICH MEDICATIONS

If you are a Medicare patient, do NOT list any medications here. Please use Current Medicaiton Form seperately provided instead.

DO YOU TAKE SUPPLEMENTS/VITAMINS?

Yes No

ARE YOU ON A SPECIAL DIET?

Yes No

DO YOU SMOKE?

Yes No

DO YOU EXERCISE?

Yes No

ARE YOU WEARING HEEL LIFTS/ARCH SUPPORTS?

Yes No

FOR WOMEN ONLY

ARE YOU PREGNANT?

Yes (____ months) No

ARE YOU NURSING?

Yes No

ALL PATIENTS PLEASE COMPLETE THIS SECTION

WHAT ARE YOU BEING SEEN FOR TODAY?

WHO HAVE YOU SEEN FOR THIS CONDITION?

Medical Doctor Chiropractor Physical Therapist Other (_____)

HAVE YOU RECEIVED ANY TREATMENT FOR THIS CONDITION?

HAVE YOU HAD ANY TEST DONE FOR THIS CONDITION?

X-Rays CT Scan MRI Other (_____)

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INSURANCE INFORMATION FORM

PRIMARY INSURANCE	PRIMARY INSURANCE POLICY NUMBER
INSURED'S NAME	INSURED'S DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE	SECONDARY INSURANCE POLICY NUMBER
INSURED'S NAME	INSURED'S DATE OF BIRTH (MM/DD/YYYY)

ARE YOU THE POLICY HOLDER ON THE INSURANCE(S)?

Yes No

If NO, please complete the following section.

POLICY HOLDER'S NAME

POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)

POLICY HOLDER'S PHONE NUMBER

PATIENT RELATIONSHIP TO POLICY HOLDER

Self Spouse Dependant Other (_____)

ARE YOU SEEKING TREATMENT AS A RESULT OF A WORK RELATED INJURY?

Yes No

ARE YOU SEEKING TREATMENT AS A RESULT OF A CAR ACCIDENT?

Yes No

ARE YOU INVOLVED IN A LAWSUIT BECAUSE OF YOUR INJURY OR SYMPTOMS?

Yes No

FOR MEDICARE PATIENTS ONLY

ARE YOU ENROLLED IN A MANAGED CARE MEDICARE PROGRAM?

Yes No

ARE YOU RECEIVING ANY TYPE OF SERVICE FROM A HOME HEALTH CARE AGENCY (HOME ATTENDANT / NURSE / PT / OT) FOR ANY REASON?

Yes No

If YES, please alert the front desk Receptionist immediately of the services you are receiving.

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF REVIEW OF NOTICE

This is to acknowledge that I have reviewed ERGO PHYSICAL THERAPY, P.C. (the Practice's) Notice of Privacy Practices. Should I have any questions regarding this Notice of Privacy Practices, I understand that I can contact ERGO PHYSICAL THERAPY, P.C. at 718-261-3100.

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INSURANCE INFORMATION AND FINANCIAL AGREEMENT

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself.

I am ultimately responsible for understanding what my policy covers and does not cover.

As a courtesy, our office will contact your insurance carrier and do its best to verify your benefits in regards to our services.

I understand that ERGO PHYSICAL THERAPY, P.C. will bill my insurance carrier directly and prepare any necessary reports and forms to file claims.

Any amount authorized to be paid to ERGO PHYSICAL THERAPY, PC. will be credited to my account upon receipt. However, I clearly understand that I am personally responsible for payment regarding services rendered at this office if my insurance does not cover it. Every attempt will be made by our office to notify you what may or may not be covered by your insurance.

I hereby authorize ERGO PHYSICAL THERAPY, P.C. to: 1. Release and/or receive any medical information necessary to Insurance Carriers and/or Medical Doctors regarding my medical condition and treatment. 2. To process insurance claims generated in the course of the examination and/or treatment 3. To receive payment to the undersigned provider for services rendered.

I further understand that fees such as co-payment, co-insurance and/or deductible are due and payable on the date services are rendered and I agree to pay all such charges in full. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all additional cost ERGO PHYSICAL THERAPY, P.C. endures during the attempt to collect such fee. Listed but not limited to: collection agency fees, attorney and court fees)

I agree to the terms and conditions presented to me by ERGO PHYSICAL THERAPY, P.C. and I acknowledge and accept these terms and conditions set forth in the above section.

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CANCELLATION/ NO SHOW POLICY

PLEASE READ CAREFULLY.
THIS POLICY IS STRICTLY ENFORCED!

In the event of a cancellation, **we require 48 hours notice**. Please have an alternative appointment time in mind when you call to enable us to reschedule your appointment. We take the subject of no shows / cancellations very seriously, because attendance and compliance will ensure a better outcome to your treatment.

When you are missing an appointment:

- You are affected because you don't receive the treatment you need as prescribed by your doctor and / or PT.
- Your Physical Therapist is affected since his/her time was reserved for you.
- Another patient is affected since he/she could have been scheduled for treatment if you had given us proper notice.

If you **No Show twice** to your appointment within your Physical Therapy Regiment, all remaining appointments will be cancelled, and you will not be allowed to schedule advanced appointments. You will not be denied care however, you will be asked to book your appointment on the day you would like to be seen. We will do our best to accommodate you when you call us on that particular day.

If you **Cancel** your appointments **three times less than 48 hours** within your Physical Therapy Regiment, all remaining appointments will be cancelled, and you will not be allowed to schedule advanced appointments. You will not be denied care however, you will be asked to book your appointment on the day you would like to be seen. We will do our best to accommodate you when you call us on that particular day.

Please cooperate with us in this regard. We are looking forward to working with you!

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