Fernando Physical Therapy Services, Inc
Patient Data Sheet

Social Security #_____-_____-_____ Last (**Referring**) Dr. Visit: _____
Patient Name_____ _____ _____
Address:_____
City:_____ State:_____ Zip:_____
Phone #:(_____)_____-_____ Work #:(____)_____-_____
Mobile #: (____)_____-_____ Spouse Mobile #: (____)_____-_____
Emergency Contact:_____ **Phone** #:_____**Relation**:_____
Birth Date:_____/_____/_____ Sex: M or F Martial Status: M S D W
Referring Dr._____ Phone#:_____
Summer Address: _____
Summer Phone #(____)_____-_____
Accident Type: W/C - Auto - None Date Of Onset:_____ Surgery? Y or N Date:_____

Authorization To Pay Benefits To Physician:

I hereby authorize the payment directly to the provider above for medical benefits and/or surgical if any, for services rendered. Also understand and agree (regardless of insurance status) I am ultimately responsible for any non-covered services and/or non-payment by the insurance carrier after 30 days.

Signature:_____ Date:_____

Authorization To Release Information:

I hereby authorize the provider above to release any information acquired in the course of my treatment necessary to process insurance claims or continue treatment with other providers.

Signature: _____ Date: _____

Consent for Therapy and Billing:

I give my consent and authorization for treatment for Physical Therapy to be rendered by a Dr. Fernando Figueroa. I also give my consent and authorization to release any information needed to make payment to the provider.

Signature: _____ Date:_____

Payment Notification:

*If our office is <u>in network</u> with your Health Insurance Company, you are responsible for deductibles, copayments, or co-insurances.
*If our office <u>is not in the network</u> with your Health Insurance Company, the billing system is as follows:
You must pay for your visits up front. This will allow you to keep the checks that will be sent to you from your Health Insurance Company to pay for the services that were rendered at our clinic.

Signature: _____ DATE: _____

SPECIAL PAYMENT ARRANGEMENTS MADE: YES OR NO

PRIVACY NOTICE

As our patient, you trust us to help achieve your physical needs. You are receiving this notice because you have the right to understand how we protect the privacy and security of the personal information that you share with us. We believe that your knowledge of our privacy principals and practices will confirm the trust you have placed with us. By signing below you will confirm that you acknowledge our efforts to provide the proper safeguards to your personal health information. In addition to this privacy act **<u>please list below who we may release your medical information to</u>** (example family member, friend or your primary care physician.
Name: _____ Name: _____

PATIENT SIGNATURE:_____ Date:_____

FERNANDO PHYSICAL THERAPY SERVICES

Medical History Please **check** if you are having or have had any of the following.

Hospitalization: last 30 days (date)_____
Allergies: _____
Diabetes: under control: yes or no
Herpes: where_____

Cancer: Type: _____
Chemotherapy: on going finished
Radiation Treatment: ongoing finished

Chest Pain
Heart Attack: Date:_____
Heart Surgery: Type:_____
High blood pressure: Lastreading date:_____/BP:_____
Congestive Heart Failure (CHF): Date_____
Edema (swelling) on feet or ankles
Cramps in the calf muscle when walking
Short of breath
Heart beats fast /irregular: last pulse check up: _____
Pacemaker/defibrillator (please circle)
Blurry Vision
Glaucoma
Macular Degeneration

Any trouble hearing
Ringing or buzzing ears
Use a hearing aide

Trouble swallowing
Constipation
Diarrhea
Hepatitis Type: _____
Any wound(s) that do not heal:
Where: _____

Back pain interfering with your activities
Joint pain and stiffness: Where:
_____
Any difficulty walking
Do you use a: cane, walker or wheelchair
Osteoporosis
Arthritis: Type:_____
Neck Surgery: Date:_____
Back Surgery: Date:_____
Knee Surgery: Date:_____
Hip Surgery: Date:_____
Fracture(broken bone) Part of Body:_____ Date:_____

Breathing difficulties
Asthma
COPD (Chronic Obstructive Pulmonary Disease)
Emphysema
Pneumonia
TB
Gout
Fibromyalgia / Polymyalgia (please circle)
Lupus

Balance difficulties
Dizziness, faintness, light headiness (please circle)
Vertigo
Blackout, lost consciousness
Epilepsy / seizures: last: _____
Stroke: last _____
Paralysis: where: _____
Tremors
Difficulty to speak
Parkinson's
Any Fall(s) when last: _____

Please circle:
Do you live alone? Yes No
Do you exercise? Yes No
Are you presently employed/working? Yes No
Are you retired? Yes No
Do you have any food restrictions? _____

Do you take any of the following:

** If you have a medication list with you, please allow us to copy for your records. If you do not have it with you, please bring it in upon your next appointment.*

Asthma medicine
Anti inflammatory pills
Blood pressure pills
Heart medicine
Diuretics, water pills
Blood thinnerpills
Tranquilizers/ sleeping pills
Diabetic pills (insulin)
Cortisone, Prednisone
Pain Pills
Dilantin
Antibiotic