RETURNING PATIENT INFORMATION SHEET

ACCT # PT

(12/2005)

Patient Name: _____

Date of Birth: _____ **SS#**: _____ (please circle :) Female Male

Has any information changed since your last visit? _____ (If yes, please fill in below.)

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Phone # _____ Work/Cell Phone # _____

Marital Status (please circle): Married Single Divorced Widowed

Primary Insurance Company: _____ Name of Insured: _____

Relationship to Insured: _____ Insured's DOB: _____

SS# of Insured: _____ Policy # _____ Group Name/Number: _____

Secondary Ins.: _____ Name of Insured: _____
Seven Oaks will only bill 2nd insurance if we are contracted provider

Relationship to Insured: _____ Insured's DOB: _____

SS# & Policy #: _____ Group Name/Number: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Are we treating the same area? (Please circle) Yes No

Date of Injury/Start of Symptoms: _____ Area of Body to be treated _____
INSURANCE REQUIRES THE DATE, MONTH AND YEAR

Type of Accident/Illness: _____ ATTY _____
(Home? Work? Sports? Auto?) Atty? No Yes If so, NAME & TEL NUMBER

Has any medical information changed since your last visit? (For example: any surgery, accidents, prescriptions, new Doctors/Dr's Tel?)

_____

I **DO HEREBY ASSIGN** all insurance benefits to be paid directly to **Seven Oaks Rehabilitation & Fitness Center** for all medical services provided to me. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided me by **Seven Oaks Rehabilitation & Fitness Center**. **I FURTHER AUTHORIZE** Seven Oaks Rehabilitation & Fitness Center to release information required regarding the course of my treatment, for the purpose of evaluating and administering claims for benefits. I understand I am responsible for services not cover by my insurance, i.e. benefits exhausted or do not meet criteria of medical necessity per your plan's guidelines. **I have been informed of & agree to abide by the cancellation policy.** **ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE MAY BE SUBJECT TO A 1.5% FINANCE CHARGE.**

_____ _____

SIGNATURE OF PATIENT/PARENT IF MINOR DATE

_____ _____

SIGNATURE OF RESPONSIBLE PARTY/PARENT IF PATIENT IS FT STUDENT DATE

IF PATIENT IS UNDER 21 AND/OR FULL-TIME STUDENT

Seven Oaks Patient Medical History Forms

Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Age: _____ Date of Injury/Onset: _____

Referring Physician: _____ Family Physician: _____

Height: _____ Weight: _____ Patient Appointment Reminder Phone #: _____

THE FOLLOWING FIVE QUESTIONS MUST BE ANSWERED

1.) For What Condition or Symptoms are You Being Seen for at This Time?

2.) When Did This Condition Begin?

3.) What Treatment Have You Already Received?

4.) Has This Problem Occurred in the Past?

5.) Have You Had Two or More Falls in the Past Year, and/or Any Fall Resulting in Injury in the Past 12 Months? YES NO

MEDICATION

Please List All Present Medications. Please Also Note Dosage/Frequency of Use.

Name of Medication	Dosage/Frequency of Use
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____
6_____	_____

PAST MEDICAL HISTORY

Please Check YES or NO Whether You Have Had the Following Conditions

Heart Disease/Heart Attack	Yes	No	Peptic Ulcer/Pancreatitis	Yes	No
Rheumatic Fever	Yes	No	Anemia/Blood Disorders	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorder	Yes	No
Stroke	Yes	No	Jaundice	Yes	No
Epilepsy or Convulsions	Yes	No	Hernia	Yes	No
Kidney or Bladder Problems	Yes	No	Thyroid Disorders	Yes	No
Diabetes	Yes	No	Venereal Disease	Yes	No
Tumor or Cancer	Yes	No	Genital/Gynecologic Disorders	Yes	No
Pneumonia or Emphysema	Yes	No	Congenital Abnormalities	Yes	No
Respiratory Disease	Yes	No	Are You Now Pregnant?	Yes	No
Tuberculosis	Yes	No	Do You Have a Pacemaker?	Yes	No
Asthma	Yes	No	Do You Have Surgical Implants?	Yes	No

Any Other Conditions Not Listed Above?

SURGERY

Please List All Previous Surgeries & Indicate the Date/Approximate Age at Time of Procedure:

Surgery/Procedure	Date/Approximate Age

FRACTURES AND OTHER SERIOUS INJURIES Please List the Type and Date
Fracture/Injury Date

ALLERGIES **Please List All Allergies**

Penicillin or Other Antibiotic: _____
Morphine, Codeine or Other Narcotic: _____
Novacain or Local Anesthetic: _____
Iodine Compounds: _____
Others Not Listed: _____

FAMILY HISTORY

Please Check Yes or No to the Following

Heart Disease	Yes	No	Bleeding Tendency	Yes	No
Cancer	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No			
Gout	Yes	No			

Please provide us with all information concerning your insurance coverage at the time of your first visit to our office.

We wish to stress that the financial responsibility for services rendered rests with the patient or their family, regardless of any insurance coverage. Remember that very few insurance policies pay 100% of the bill submitted. We strongly recommend each patient/guardian/primary cardholder call your insurance company and review your individual policy concerning physical therapy coverage.

_____ _____

Patient Signature/Responsible Party Date

INFORMED CONSENT FOR PHYSICAL THERAPY TREATMENT

Welcome to Seven Oaks Physical Therapy and Fitness Center. This form is an effort by Seven Oaks to provide you with information about your physical therapy treatment here at Seven Oaks that is administered by the physical therapist, physical therapy assistant or other ancillary personnel. The purpose of "informed consent" is to provide you with sufficient information so that you can make an "informed" decision regarding your consent to physical therapy treatment. It is our desire and goal to provide you with appropriate and safe treatment that will result in an improvement in your particular condition. However, because there are many factors and issues involved in a specific individual's medical condition and treatment we are unable to guarantee that every individual medical condition will respond positively to treatment.

Physical therapy involves many types of treatments, procedures and modalities. The type of treatment the therapist incorporates into your treatment care plan is generally based on the information gleaned from the prescription of your referring physician, your initial evaluation, and your response to various types of procedures employed during your treatment. Your treatment may be altered or changed by the therapist based on your response to current treatment and as your condition changes. As you may be aware there are benefits and risks associated with all types of medical treatment and this includes physical therapy treatment. While it may be possible to make an extended and long list of potential risks from all types of physical therapy treatment it is not practical nor is it likely to result in providing you with information that allows you a better understanding of "risks vs. benefits". We encourage you to ask your therapist about any concerns or questions you may have regarding your treatment. He or she will be glad to discuss and review any particular treatment that you are receiving.

Manual therapy (includes joint mobilization, soft tissue mobilization, and manual traction) and therapeutic exercise are frequent procedures utilized at Seven Oaks that we believe provide our patients with significant benefits. Manual therapy involves applying varying degrees of pressure with the therapist's hands on the treatment area or surrounding area of your body. Manual therapy and exercise have inherent physical risks associated with them. These risks may include, but are not limited to, muscle and soft tissue strains or soreness, joint strains and sprains, intravertebral disc injury, heart attacks or cardio-vascular complications, bone injuries, strokes, and other complications known and unknown at this time.

By signing this form you are consenting to treatment by Seven Oaks Physical Therapy and Fitness Center, Inc. You are acknowledging that you understand and are accepting the benefits and risks of physical therapy treatment. You understand that you may question your physical therapist at any time regarding your treatment and that you may decline any proposed treatment or stop any treatment at any time that is currently being utilized.

Patient Signature _____ Date _____

APPOINTMENT CONFIRMATION PREFERENCE

To all Seven Oaks patients,

We will be making changes to our appointment reminder system,

Please check one of the following:

_____ would like to receive:

○ **A confirmation phone call**

○ **A confirmation text message**

○ **Do not call or text me to remind me**

Preferred phone number for confirmation _____