

# BUCKEYE PHYSICAL MEDICINE AND REHAB - GAHANNA PATIENT INTAKE

## GENERAL INFORMATION

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M D W  
Drivers License Number and State issued \_\_\_\_\_ State \_\_\_\_\_  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic text reminders?  Yes  No If yes, who is your cell phone provider? \_\_\_\_\_

## ACCIDENT INFORMATION

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other Date of Accident \_\_\_\_\_  
Has the accident been reported?  Yes  No To Whom? \_\_\_\_\_ Claim Number \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

**Signature of Patient**/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

## HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Eczema     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        | _____                                       |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke               | _____                                       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Suicide Attempt      |   |

Are you currently pregnant?  Yes  No

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking (Be sure to include dosage and frequency) \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date) \_\_\_\_\_

Please list any supplements you are currently taking (vitamins, minerals, herbs) \_\_\_\_\_

Are you currently on any blood thinners – (aspirin regimen included)?  Yes  No List Type \_\_\_\_\_

**Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.**

Please CHECK if you have any of the following:

- A pacemaker  Suffer from blood clots  Knee/ hip replacement  Local or systemic infection  Egg allergy
- Corticosteroid or Local Anesthetic Allergy  Additional allergies (please list) \_\_\_\_\_

**Is there a family history of any of the following conditions?** (Indicate family member including parents, grandparents & siblings)

- Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Other \_\_\_\_\_
- Cancer \_\_\_\_\_  Arthritis \_\_\_\_\_  Other \_\_\_\_\_

Do you exercise?:  Yes  No How often?: 1X 2X 3X 4X 5X per week Other: \_\_\_\_\_

Which activities:  Running  Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other \_\_\_\_\_

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Energy Drinks \_\_\_\_\_ cups/day Cigarettes \_\_\_\_\_ packs/day

**I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.**

Patient's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Reviewed Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

## RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Buckeye Physical Medicine and Rehab – Gahanna and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial )

**Signature of Patient**/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATION OF CARE

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

**NAME OF GUARANTOR** (person responsible for guaranteeing payment for all services) \_\_\_\_\_

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minors Name

\_\_\_\_\_  
Guardian/Spouse's Signature of Authorizing care for minor

\_\_\_\_\_  
Date

I hereby authorize Buckeye Physical Medicine and Rehab – Gahanna to administer care as deemed necessary to my child, a minor under the age of 18 years old.

## EMERGENCY CONTACT

Name \_\_\_\_\_

Work Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT  
(CONSENT TO USE PHI)**

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**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Buckeye Physical Medicine and Rehab - Gahanna or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below, I give my permission to use and disclose my health information as stated in the notice of privacy practices.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date