Crete Physical Therapy

830 E 1st Street, P.O. Box 294 Crete, NE 68333

Patient Information Form

Date _____

Patient Information:

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Email Address (optional):_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Gender: M or F Marital Status: Single Married Widowed Divorced

Employer: _____ Occupation: _____

Who referred you to our office? _____

Reason for visit: _____ Onset of current condition: _____

Do you reside in a long-term care or skilled nursing facility? Y or N

_____

If someone other than the patient being seen is responsible, please list responsible party below:

Responsible Party Name: _____ Responsible Party Date of Birth: _____

Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

_____

In case of Emergency:

Who would you like us to contact in case of emergency?

Name: _____ Phone Number: _____ Relationship to patient: _____

_____

Insurance Information:

Primary Insurance Company: _____

Primary Insured Name: _____ Primary Insured Date of Birth: _____

Relationship to patient: _____

Primary Insurance ID #: _____ Primary Insurance Group #: _____

Secondary Insurance Company: _____

Primary Insured Name: _____ Primary Insured Date of Birth: _____

Relationship to patient: _____

Secondary Insurance ID #: _____Secondary Insurance Group #: _____

Worker's Compensation or Auto Accident Information:

Were you injured at your job? If so, please complete the following information.

Employer Name: _____ Contact Person: _____ Phone Number: _____

How were you injured: _____ Date of injury: _____

Worker's Comp insurance company name: _____Claim #: _____

Were you involved in an auto accident? If so, please complete the following information.

Auto Insurance Company: _____

Contact Person: _____ Phone Number: _____

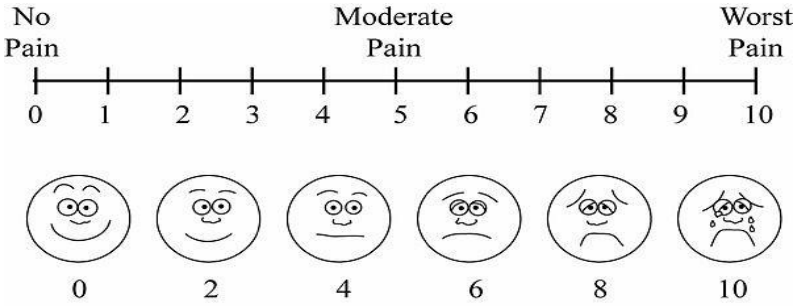
Claim #: _____ Date of accident: _____

Are you currently working with an attorney? If so, please list below:

Name of Attorney: _____ Phone Number: _____

PQRS Information:

1. Pain Status: Where is your pain located? _____



2. History of Falls:

Number of falls in the past 12 months: _____

Injuries from falls (please specify): _____

3. Please list all medications you are currently taking:

_____

_____

_____

Current known medical conditions:

_____

Previous Surgeries and approximate date of surgery:

_____

Consent for Treatment/ Assignment of Benefits/ Release of Information

I understand that I have been referred to Crete Physical Therapy, Inc. and authorize Crete Physical Therapy, Inc. to provide rehabilitation services as per my referral and/or developed, modified, and progressed at the direction of Crete Physical Therapy, Inc. clinicians and/or my physician. I also assign directly to Crete Physical Therapy, Inc. ass medical benefits payable to my insurance company, Medicaid, or Medicare benefits. I authorized release of any records necessary to secure payment of benefits to my insurance company, Medicaid, or Medicare.

Medicare patients only: Certification and Financial Agreement- I certify that the information given by me is applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed for this or a related Medicare claim. I request that the payment for authorized benefits be made directly to Crete Physical Therapy on my behalf. I understand that I am responsible for any medical insurance deductible and co-insurance, and for the cost of the difference of any private accommodation in which I am placed at my own request.

Patient Name: _____ Date: _____

Patient Signature: _____

Office Use Only

Diagnosis: _____