DELTA/FILLMORE PHYSICAL THERAPY & SPORTS MEDICINE

95 S White Sage Ave, Suite C
Delta, UT 84624
(435)864-2551

674 S Highway 99
Fillmore, UT 84631
(435)743-6100

Date_____
Patient_____ Date of Birth _____/_____/_____
Social Security Number_____-_____-_____ Sex: M F
Mailing Address_____ City_____ State _____ Zip Code_____
Street Address_____ City_____ State_____ Zip Code_____
Single Married Widowed Separated Divorced
Preferred Contact: ☐ Home ☐ Cell ☐ Email
Home Phone _____ Cell Phone _____
Email Address_____

In accordance with the Health Insurance Protability and Accountability Act of 1996 (HIPPA), we ask that you provide the name and date of birth of family members we may discuss your treatment, condition(s), and/or billing information with:

_____

_____

RESPONSIBLE PARTY INFORMATION ☐ Self ☐ Relationship to Patient:_____
Name_____
Mailing Address_____ City_____ State_____ Zip Code_____
Social Security Number _____-_____-_____ Phone Number_____
Occupation/Employer of Responsible Party_____
Business Address_____ Business Phone Number_____
Emergency Contact _____ **Phone Number** _____

INSURANCE INFORMATION ☐Medical ☐Workers Comp

PRIMARY INSURANCE
Insurance Name_____
Policy Holder_____
Policy Holder Birthday_____/_____/_____
Policy Number_____
Insurance Phone Number_____

SECONDARY INSURANCE
Insurance Name_____
Policy Holder_____
Policy Holder Birthday_____/_____/_____
Policy Number_____
Insurance Phone Number_____

Consent of Treatment: On behalf of the patient, consent is hereby given to the facility, its contractors, medical staff, and employees to provide health care services to the patient and to administer physician orders for the benefit of the patient for this visit and any subsequent visits, and it is understood that this consent may be revoked in writing at any time. It is understood that there is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such service. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty cases, to obtain seperate consent for some of the services they perform.

Release of Information: The law requires health care providers to make and keep records of your treatment. These records are safeguarded by the facility. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at this facility, you agree to the release of medical record information for the uses specified above. You also agree to the release of claims related information to insurance companies or other third parties to assist in paying your health care costs.
Our clinic will occasionally use photographic documentation to track progress and status. This documentation will be placed in your electronic file and used for billing and may be released to your physician if requested. By signing below, you acknowledge and consent to this type of documentation.

Assignment of Benefits: The patient and the undersigned, if other than the patient, do hereby authorize carrier(s) to pay directly to Delta/Fillmore Physical Therapy and Sports Medicine Clinic, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions.

Terms: A finance charge of $10.00 will be added to the unpaid balance monthly if your account should age past 75 days without any payments or arrangements made with Office Manager. Should collection become necessary, the responsible party agrees to pay an additional 50% collection fee, and legal fees of collection, with or without suit, including attorney fees and court costs.

In accordance with HIPPA, which became effective on April 14, 2003, we are required to provide you a copy of your "Notice of Privacy Practices," before Delta/Fillmore Physical Therapy can use or disclose your private health care operations.

_____ _____
Signature of Insured/Guardian **Date**

Health History/Review of Systems

Date_____

Patient Name_____ **Sex: M / F**

Date of Birth _____/_____/_____

Height:_____ **Weight:**_____

Patient Health History

	Yes	No
Asthma	( )	( )
Stroke	( )	( )
Heart Trouble	( )	( )
High Blood Pressure	( )	( )
Diabetes	( )	( )
Arthritis	( )	( )
Gout	( )	( )
Seizures	( )	( )
Mental Illness	( )	( )
Kidney Trouble/Stones	( )	( )
Cancer	( )	( )
Bleeding Disorders	( )	( )
Alcoholism	( )	( )
Serious Injury	( )	( )
Lung Disease	( )	( )
Tuberculosis	( )	( )
Phlebitis	( )	( )
Anemia	( )	( )
Stomach Ulcers	( )	( )
Liver Trouble	( )	( )
Thyroid Trouble	( )	( )
Other Illnesses	( )	( )

Explain all Yes answers:

_____
_____
_____
_____
_____
_____

Surgical Procedures (include dates)

_____
_____
_____
_____
_____

Current Medications/Dosages (Including Over the Counter)

_____
_____
_____
_____
_____

Allergies **None ( )**

_____
_____
_____
_____
_____

Family History

	Yes	No
Stroke	( )	( )
Heart Trouble	( )	( )
High Blood Pressure	( )	( )
Diabetes	( )	( )
Arthritis	( )	( )
Gout	( )	( )
Seizures	( )	( )
Mental Illness	( )	( )
Kidney Trouble/Stones	( )	( )
Cancer	( )	( )
Bleeding Disorders	( )	( )
Alcoholism	( )	( )
Other	( )	( )

Explain all Yes answers:

_____
_____
_____
_____
_____
_____

Cause of Death of Parents, Brothers, Sisters:

_____
_____
_____
_____
_____

Social History

Most Recent Occupation

_____
_____

Number of Pregnancies _____
Number of Children Living_____

Presently Living Alone: YES NO

Smoke_____Packs per Day

Alcohol: Never ( ) Occasional ( )
Moderate to Heavy ( )

Drug Overuse: None ( )
Presently ( ) Past Problem ( )

Review of Systems

Have you recently had or do you now have:

	Yes	No
Reading Glasses	( )	( )
Change of Vision	( )	( )
Loss of Hearing	( )	( )
Ear Pain	( )	( )
Hoarseness	( )	( )
Nose Bleeds	( )	( )
Difficulty Walking	( )	( )
Morning Cough	( )	( )
Shortness of Breath	( )	( )
Chills or Fever	( )	( )
Heart or Chest Pain	( )	( )
Abnormal Heartbeat	( )	( )
Badly Swollen Ankles	( )	( )
Calf Cramps w/ Walking	( )	( )
Poor Appetite	( )	( )
Toothache	( )	( )
Gum Trouble	( )	( )
Nausea or Vomiting	( )	( )
Stomach Pain	( )	( )
Ulcers	( )	( )
Frequent Belching	( )	( )
Frequent Loose Bowel Mvmt	( )	( )
Blood in Bowel Mvmt	( )	( )
Frequent Constipation	( )	( )
Hemorrhoids	( )	( )
Frequent Urination	( )	( )
Burning with Urination	( )	( )
Difficulty Starting Urination	( )	( )
Difficulty Stopping Urination	( )	( )
Get up Every Night to Urinate	( )	( )
Frequent Rash	( )	( )
Hot or Cold Spells	( )	( )
Recent Weight Change	( )	( )
Nervous Exhaustion	( )	( )
Insomnia	( )	( )
Depression	( )	( )
Nervous Tension	( )	( )
WOMEN ONLY!!	( )	( )
Irregular Periods	( )	( )
Vaginal Discharge	( )	( )
Frequent Spotting	( )	( )

Do you have a pacemaker?	YES	NO
Are you taking any Nitro for any heart condition?	YES	NO
If yes, do you have it with you?	YES	NO
If you have allergies, do you have a prescribed EpiPen?	YES	NO
If yes, do you have it with you?	YES	NO