

BUCKEYE PHYSICAL MEDICINE AND REHAB - EASTLAND, LLC

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 _____

ACCIDENT INFORMATION

Is this visit related to the **auto accident** Yes No If so, when was the date of the accident _____

Please describe in detail the accident (use the back of this sheet if needed): _____

Please answer the following questions about the accident:

1. Were you the driver the passenger a pedestrian on a bicycle on a motorcycle.
2. Were you hit (by another vehicle) or at fault (you caused the accident)?
3. From which side were you struck behind the front the right side the left side the right front the left front the right back the left back.
4. At the time of impact were you stopped moving walking standing still running bicycling riding a motorcycle crossing the street.
5. Were you moving at the time of the accident yes or no? **If yes**, what was your speed _____?
6. Was the involved party moving when the accident occurred yes or no, **If yes** what was their speed _____?
7. Did you have your seatbelt on at the time of the accident yes no?
8. Was your head turned at the time of the accident yes or no, **If yes** were you looking forward looking to the right looking to left looking behind you looking up looking down.
9. Were you alone at the time of the accident yes or no? **If no** who was with you _____?
10. What parts of your body hit other structures at the time of impact head face forehead back of head right TMJ left TMJ
 right shoulder left shoulder right arm left arm right elbow
 left elbow right wrist left wrist right hand left hand
 Right leg left leg right knee left knee right ankle left ankle
 right foot left foot
11. What structures did you hit? steering wheel windshield side window door roof dashboard
 headrest seat floor Side of car hood of car bumper trunk
 the pavement tree another car another person another object
 a wall
12. How did you feel after the collision? stunned disoriented lost consciousness tightness felt mild discomfort felt moderate discomfort felt severe discomfort felt intense pain frightened felt a popping and ripping sensation went to hospital
13. Who was cited for the accident me other driver
14. Have you had one or more of the following symptoms since your accident? Cannot sleep due to the accident
 having trouble getting to sleep since the accident Lost time from work due to the accident have been depressed since the accident occurred
15. Have you been treated for injuries related to the accident already? yes no
If yes, by whom? _____ Did they perform any diagnostic testing? yes no
16. Have you lost wages or not been able to work due to the accident? yes no

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 _____

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

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 - Eastland 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