

BAYSIDE PHYSICAL THERAPY & SPORTS REHABILITATION PATIENT DATA SHEET

First: _____ MI: _____ Last: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Mailing Address: _____

Physical Address: _____

May we send you text messages relating to your care with us? Yes No

By providing your text number below, you understand that text messages will NOT be sent via secure, encrypted format.

OK To Call	OK To Text	Phone:	Best Time To Call
<input type="checkbox"/>	<input type="checkbox"/>	Home: _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Work: _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cell: _____	_____

SSN: _____

May we send you emails relating to your care with us? Yes No

By providing your email address below, you understand that emails will NOT be sent via secure, encrypted format.

Email: _____

Preferred language:

Intepreter required? Yes

Married Single Divorced Widowed Separated Unknown

Student Status: Full-Time Part-Time None

Date of Injury: _____ Referring Physician: _____

Injury Area: _____

Auto or Work Accident: _____

EMPLOYMENT STATUS

Employment Status:

 Active Military
 Full-Time
 None
 Part-Time
 Retired
 Self Employed

Employer:

Occupation:

Address:

Phone:

Employer:

Occupation:

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name:

Holder's Birth Date:

Policy or Certificate #:

Group #:

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name:

Holder's Birth Date:

Policy or Certificate #:

Group #:

Policy Holder's Employer:

 Are you receiving or have you received Home Health Services? Yes No

 Are you receiving or have you received other therapy services? Yes No

How did you hear about us?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | <input type="checkbox"/> Marketing Ad - Facebook |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | <input type="checkbox"/> Marketing Ad - Other |

Specify if other : _____

Note: Please provide us with the most updated information down below.

CONTACTS

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DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C#	Name	A/C Type	Office
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CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

BAYSIDE PHYSICAL THERAPY & SPORTS REHABILITATION

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.

TREATMENT OF MINORS:

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY

I know and agree that: BAYSIDE PHYSICAL THERAPY & SPORTS REHABILITATION is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE

I hereby release, discharge and acquit:

BAYSIDE PHYSICAL THERAPY & SPORTS REHABILITATION

its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:

BAYSIDE PHYSICAL THERAPY & SPORTS REHABILITATION

I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY

I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

BAYSIDE PHYSICAL THERAPY & SPORTS REHABILITATION MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
 REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
 PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? YES NO
 CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
 IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____
 AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
 WHAT WAS DONE? / WHAT WERE THE RESULTS?: _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
 WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
 FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Other _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____

Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> BLOOD THINNERS (Anticoagulants) |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus) | |
| <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of Bayside Physical Therapy & Sports Rehabilitation. This form must be completed in its entirety and must be provided to Bayside Physical Therapy & Sports Rehabilitation prior to initiation of therapy services. Revised 4.16.15 KB

**CONSENT TO USE OF LIKENESS AND
TESTIMONIAL AND RELEASE**

I, _____, hereby consent to allow Bayside Physical Therapy & Sports Rehabilitation and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

Participant Name

Date

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, _____, hereby consent and authorize Bayside Physical Therapy & Sports Rehabilitation and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

Participant Name

Date

Parent/Legal Guardian (If Participant is a Minor)