

# Atlantic Physical Therapy & Rehabilitation

## **Patient History**

OFFICE USE Patient Account # \_\_\_\_\_ Department Treating \_\_\_\_\_

**PLEASE COMPLETE ALL FORMS ATTACHED!**

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender: Male Female Marital Status: Single Married Divorced Widowed Other: \_\_\_\_\_

Employers name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you here about us? Please circle one: Doctor Referral, Newspaper, Friend, Previous Patient, Website, Telephone,

Walk In, Other: \_\_\_\_\_

Who to notify in an emergency?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your injury a result of (circle): WORK, AUTO, or OTHER Date of Injury? \_\_\_\_\_

Attorney Name/Phone/Address \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

## **Past Medical History**

Major Surgical Procedures: \_\_\_\_\_

Medications: \_\_\_\_\_

**PHYSICAL/OCCUPATIONAL OUTPATIENT THERAPY TREATMENT CONDITIONS \*Any reference to "clinic" is known as Atlantic Physical Therapy & Rehab and its employees**

### **CONSENT TO TREATMENT**

Any patient who is referred for treatment to our clinic is still under the supervision of his/her physician, as well as, the physical/occupational therapist for the treatment of his/her condition. The patient consents to any treatment necessary as prescribed by his/her physician. The patient recognizes that all therapists that consult and furnish services ordered by the referring physician are privileged to provide such services. We (Atlantic Physical Therapy & Rehab and its employees) are not liable if the patient does not follow the instructions of his/her attending physician/therapist during the course of outpatient therapy.

### **RELEASE OF INFORMATION**

The clinic may disclose all or any part of the patient's medical record to any person or corporation that is liable for the clinic's charge including, but not limited to insurance companies, medical service companies, review agencies, workman's compensation carriers/attorneys, automobile insurance/attorneys, welfare funds and other government insurance companies. This release is strictly for reimbursement purposes to the clinic for services rendered.

The clinic may disclose all or any part of the patient's medical record for this admission to the referring physician, social worker, claims adjuster, treating physician, or family physician or other treatment agencies to aid in the continuing once discharged from the clinic. Authorization must be signed by the patient or, in case of a minor or when a patient is physically or mentally incompetent by the nearest relative or legal guardian.