welcome to Orthopaedic Physical Therapy Institute

We are glad you chose OPTI for your physical therapy needs. Although we are anxious to get you started on the road to recovery, there is some vital information we need first to serve you more effectively. Please fill out this form completely. We realize it is a pain, but we specialize in relieving pain!

1 ABOUT YOU

Today's Date:_____

Name:_____
LAST FIRST MI MR MRS MS DR

I prefer to be called_____ Male ☐ Female ☐

Birthdate:_____ Age:_____ Soc. Security #:_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Home Address:_____ Apt/Condo #:_____

_____
CITY STATE ZIP

Home Phone #: ( ) _____ Pager/other: ( ) _____

Work #: ( ) _____ Ext._____ Drivers License #:_____

Employer:_____ Phone #: ( ) _____ How long there:_____

Occupation:_____ When & where are the best times to reach you?_____

Whom may we thank for referring you?_____ Date of injury we are treating you for?_____

Have you had physical therapy this year?_____ Name of Facility/Therapist:_____ Last visit date:_____

In the event of an emergency is there someone who lives near you that we should contact?_____

Relationship:_____ Work Phone #: ( ) _____ Home Phone #: ( ) _____

2 SPOUSE INFORMATION

His / Her name:_____

Employer:_____ Work Phone #: ( ) _____ Ext._____

Soc. Security #:_____ Birthdate:_____ Drivers License #:_____

Name of person responsible for account:_____

Work Phone #: ( ) _____ Ext._____ Home Phone #: ( ) _____

Soc. Security #:_____ Drivers License #:_____ Birthdate:_____

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

3 WORKER'S COMPENSATION PATIENT'S

Employer at time of injury:_____

Employer's Address:_____ Employer's Phone #: ( ) _____

Claim #:_____ Adjuster's name:_____

Insurance name:_____ Insurance Phone #: ( ) _____

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

4 PRIVATE INSURANCE / MEDICARE PATIENTS

Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's SS#:_____ Insured's Birthdate:_____

Insured's Employer:_____

Secondary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's SS#:_____ Insured's Birthdate:_____

Insured's Employer:_____

5 MEDICAL HISTORY

Do you have a personal physician? Yes ☐ No ☐

Physician's Name: _____

Phone #: ( ) _____ Date of last visit: _____

Your current physical health is Good ☐ Fair ☐ Poor ☐

Are you taking any prescription / over the counter drugs? Yes ☐ No ☐

Please list each one: _____

Do you smoke or use tobacco in any form? Yes ☐ No ☐

FOR WOMEN ONLY: Are you pregnant? Yes ☐ No ☐

Are you nursing? Yes ☐ No ☐

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Low Blood Pressure
Y	N	Anemia	Y	N	Frequent Headaches	Y	N	Nausea
Y	N	Arthritis	Y	N	Glaucoma	Y	N	Pacemaker
Y	N	Artificial Bones/Joints/Valves	Y	N	Heart Attack	Y	N	Psychiatric Problems
Y	N	Asthma	Y	N	Heart Problems/Defects	Y	N	Radiation Treatments
Y	N	Cancer/Chemotherapy	Y	N	Heart Surgery	Y	N	Rheumatic/Scarlet Fever
Y	N	Colitis	Y	N	Hemophilia	Y	N	Ringing in ears
Y	N	Congenital Heart Defect	Y	N	Hepatitis	Y	N	Seizures
Y	N	Diabetes	Y	N	Hernia	Y	N	Shortness of breath
Y	N	Difficulty Breathing	Y	N	High Blood Pressure	Y	N	Skin Disorders
Y	N	Dizziness	Y	N	HIV +/AIDS	Y	N	Sickle Cell Disease
Y	N	Difficulty Standing	Y	N	Hospitalized for any reason	Y	N	Stroke
Y	N	Emphysema	Y	N	Kidney Problems	Y	N	Thyroid Problems
Y	N	Epilepsy	Y	N	Liver Problems	Y	N	TMJ (Jaw Problems)
						Y	N	Tuberculosis (TB)

Please list any allergies you have _____

Are you sensitive to Hot or Cold? Yes ☐ No ☐ Please specify _____

Are you aware of loss of feeling anywhere on your skin? Yes ☐ No ☐ Please specify _____

List previous surgeries and dates _____

Are there any other concerns for your health we should know about? _____

6 CONSENT TO TREAT

I authorize the physical therapy staff of OPTI to perform any necessary physical therapy services during evaluation and treatment with informed consent on myself / daughter / son.

Print patient's name: _____

Patient / Parent signature: _____

7 SIGNATURE ON FILE (required for billing your insurance company for you)

Please initial and sign at bottom

_____ I authorize use of this form on all my insurance submissions.
_____ I authorize release of information to all my insurance companies.
_____ I authorize my physical therapist to act as my agent in helping me obtain payment from my insurance companies.
_____ I authorize payment direct to my therapist.
_____ I permit a copy of this authorization to be used in place of the original.
_____ I understand that I am responsible for my bill (except worker's comp.)

Patient / Parent signature: _____

OPTI PAYMENT POLICY:
Unfortunately, we do not accept liens or contingency cases. Any co-payments you may have are due on the day service is rendered unless other arrangements have been approved by OPTI. The undersigned below understands and agrees that regardless of insurance status, he/she is ultimately responsible for the balance of his/her account for the professional services rendered by OPTI.

MEDICARE PATIENTS ONLY:
Medicare has a deductible. They only pay a percentage of the billed charges. Either you or your secondary insurance are responsible for the remaining charges. Medicare will not cover orthotic devices, supplies, supports, braces or exercise equipment.

G-SHIP PATIENTS ONLY:

Visits 1 thru 10 _____ CO-PAY

Signature: _____ Date: _____