SMOKY MOUNTAIN
SPORTS MEDICINE & PHYSICAL THERAPY

NEW PATIENT INFORMATION FORM

(Print name AS APPEARS ON insurance card)

PATIENT INFORMATION

Patient's First name: MI: Last Name:			Date of Birth: / /
Social Security #	❑Male ❑Female		Preferred Name/Pronouns:
Mailing/Billing address:			
City:	State:	Zip Code:	Primary Contact Number: ( )
Occupation:	Employer name and address:		Employer phone no.: ( )
Email Address: ❑ I consent to receiving marketing emails.			Reminder Preference: ❑ Email ❑ Text ❑ Call

EMERGENCY CONTACT INFORMATION

Patient Emergency Contact: _____

Relationship to Patient: _____

Contact Phone #: _____

ACCIDENT DETAIL INFORMATION

PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: ❑ Yes ❑ No	Accident related: ❑ Auto ❑ Yes ❑ No	Date of first symptom or accident: / /
Give details of accident:		

REFERRAL INFORMATION

Referred to clinic by (please check one box):
❑ Dr._____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

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Name: _____ Age: _____ DOB: _____

Primary Care Physician/Family Physician: _____

Leisure activities, including exercise routines: _____

Occupation: _____ Are you on a work restriction from your doctor? **YES** **NO**

Do you smoke? **YES** **NO** Are you latex sensitive? **YES** **NO**

Do you have a pacemaker? **YES** **NO** Please list any known allergies _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES** **NO**

Have you RECENTLY noted any of the following (check all that apply)?

fatigue
fever/chills/sweats
nausea/vomiting
weight loss/gain
falls
difficulty maintaining balance
numbness or tingling
muscle weakness
dizziness/lightheadedness
heartburn/indigestion
diarrhea
constipation
changes in bowel/bladder function
difficulty swallowing
shortness of breath
fainting
cough
headaches
currently feeling down or hopeless

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

Cancer
Heart problems
Chest pain/angina
High blood pressure
Circulation problems
Blood clots
Stroke
Anemia
Chemical dependency
Depression
Lung problems
Tuberculosis
Asthma
Rheumatoid arthritis
Other arthritic condition
Bladder/urinary tract infection
Sexually transmitted disease/HIV
Incontinence
Thyroid problems
Diabetes
Osteoporosis
Fractures
Multiple sclerosis
Epilepsy
Kidney problems
Ulcers
Liver problems
Hepatitis
Other: _____

Please list prior surgeries and date(s) _____

Date of injury/onset of current symptoms _____ Date of surgery_____

What do you think caused your symptoms? _____

Please circle any of the following services that you are receiving currently or have had this year calendar:

Physical Therapy Occupational Therapy Chiropractic Care Massage Therapy Speech Therapy

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan Other: _____

Have you ever had this problem before? **YES** **NO** If yes, when? _____

In your current living environment: Do you have stairs? **YES** **NO**. How Many Steps to enter home _____ In Home_____

Do you live alone? **YES** **NO.** If NO with whom? _____

Have you had any recent falls? **YES NO** If so, how many _____? When did fall(s) occur? _____

How would you rate your overall quality of life? Excellent Good Fair Poor

Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

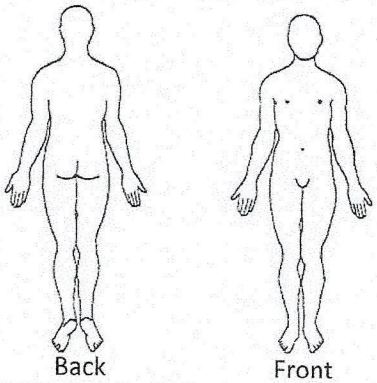
1. _____
2. _____
3. _____

Pain Assessment:

Using the scale below, please circle the **WORST** your pain has been during the **past 24 hours**.
0 = no pain, 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

On the chart to the right, please mark the areas where you feel PAIN with an "**O**" and NUMBNESS/TINGLING with an "**X**".



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Medication Assessment:
Please list any medications you are currently taking (including pills, injections, skin patches, vitamins, herbs, etc):

Medication Name	Dosage	Frequency	Route of Administration (circle how you take this med)
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch

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CONSENT TO TREAT AND CONDITIONS OF ADMISSION

1 CONSENT TO REHABILITATION PROCEDURES: The undersigned consents to the procedures which may be performed during this and future outpatient physical therapy visits that are performed at Smoky Mountain Sports Medicine and Physical Therapy. I/We consent to examination, therapy procedures and therapy care given to the patient by or under the supervision of the physical therapist.

2 LEGAL RELATIONSHIP BETWEEN SMOKY MOUNTAIN SPORTS MEDICINE AND PHYSICAL THERAPY PHYSICAL THERAPISTS: All Physical Therapists (PT), and Physical Therapist Assistants (PTA) are employed by Smoky Mountain Sports Medicine and Physical Therapy, LLC. Smoky Mountain Sports Medicine and Physical Therapy serves as a medical teaching facility; therefore, physical therapist students, physical therapist assistant students and physical therapy residents may be involved in your care under the supervision of an attending PT or PTA.

3 FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Smoky Mountain Sports Medicine and Physical Therapy in accordance with the regular rates and terms of Smoky Mountain Sports Medicine and Physical Therapy. All accounts are handled by an independent billing company, including billing, collections and all other matters relating to the account.

4 ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Smoky Mountain Sports Medicine and Physical Therapy of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed Smoky Mountain Sports Medicine and Physical Therapy's regular charges. It is agreed that payment to Smoky Mountain Sports Medicine and Physical Therapy, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. **Any pre-certification of insurance benefits is the patient's sole responsibility;** however, Smoky Mountain Sports Medicine and Physical Therapy will make every effort to get this as a courtesy to the patient. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by Smoky Mountain Sports Medicine and Physical Therapy. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

5 PHOTOGRAPHING AND VIDEOTAPING: Smoky Mountain Sports Medicine and Physical Therapy may photograph, film, videotape or otherwise make video and/or audio recordings of the patient only for purposes of diagnosing and treating the patient's condition. No photograph or videotape will be used for any other purpose other than treatment without the patient's written consent.

6 DISCLOSURE OF HEALTH INFORMATION: I understand that Smoky Mountain Sports Medicine and Physical Therapy is a health provider who must comply with the Health Insurance Portability and Accountability Act of 1996. HIPAA protects the privacy of individually identifiable health information. The Smoky Mountain Sports Medicine and Physical Therapy Notice of Privacy Practice outlines your rights and our responsibilities regarding your medical information and who to contact if you have any concerns regarding your medical information. Your initials below acknowledge that you have been given a copy of the Smoky Mountain Sports Medicine and Physical Therapy Notice of Privacy Practices.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

_____ _____

Patient/Guardian Signature **Date**

_____

Print Patient Full Name