DESERT PINES REHABILITATION

REHABILITATION ~ CHIROPRACTIC ~ PHYSIOTHERAPY

Welcome To Our Office!

New Patient Information
(Or Update Information)

PATIENT INFORMATION

Date _____/______/______ Patient Name ____
(Last) (First) (Init.)

Date of Birth ________/________/_________ Age ________________ Sex: ❐ M ❐ F

Social Security # ______________________ Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Widowed

Address _____________________________ City________________________ State ________ Zip Code ___________

Home # _____________________________ Mobile #_____________________ Work # _________________________

E-Mail: ______________________________ Occupation __________________ Employer _______________________

Primary Physician _____________________ Phone # ____________________ Fax # ___________________________

Emergency Contact ____________________ Relationship_________________ Phone # _________________________

Spouse Name ________________________ Date of Birth _____/______/_____ Social Security # __________________

Spouse Employer ____ Phone # _________________________

CHIEF COMPLAINTS

Chief complaints ____

Cause of chief complaints ____

When did your symptoms appear? ____________________________________

What treatment have you received for this condition?

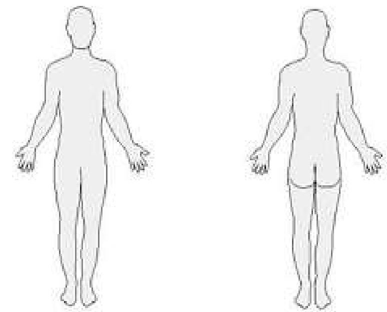
❐ Medical ❐ Chiropractic ❐ Physical Therapy ❐ None

Severity of your pain on a scale from **0** (no pain) to **10** (severe pain) ___________

Type of Pain ❐ Sharp ❐ Dull ❐ Numbness ❐ Shooting

❐ Burning ❐ Cramping ❐ Stiffness ❐ Other ___________

Are you pregnant? ❐ Yes ❐ No ❐ Male



Shade in your area of Complaint

Medications you are currently taking ____ ❐ None

MEDICAL HISTORY

Injuries ____ Date: ___________________

Illnesses ____ Date: ___________________

Surgeries ____ Date: ___________________

INSURANCE INFORMATION

Primary Insurance: ______________________________ Telephone # ____________________

Address ______________________City ______________ State __________Zip_____________

Name of Policy Holder______________________________ Date of Birth _______/______/______

Relationship to Patient___________________Employer______________________________

Member Id #______________________Group Id #_______________Social Security # ________________

Secondary Insurance: ______________________________ Telephone # ____________________

Address ______________________City ______________ State___________ Zip____________

Name of Policy Holder ______________________________ Date of Birth ______/______/_______

Relationship to Patient ___________________Employer______________________________

Member Id #______________________Group Id #_______________Social Security # ________________

HIPPA/ INSURANCE AUTHORIZATION & RELEASE

HIPAA COMPLIANCE

- Your personal health information cannot be shared unless to prevent serious threat to your health or others.
- Your personal health information may be disclosed, if required to do so by law.
- You have the right to access your medical file and billing records.
- You have the right to request that we amend your information.
- You may revoke any written authorization given to us.
- All requests must be presented to this office in writing.

I allow my treatment to be discussed with ______________________________Relationship____________________

INSURANCE ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **DESERT PINES REHABILITATION.** I authorize **DESERT PINES REHABILITATION** to release any information required to process my claims. I understand it is my responsibility to make sure my account is paid by my insurance company. I have verified with my insurance company that **DESERT PINES REHABILITATION** is a participating provider. I understand that I am fully financially responsible if there are any unpaid claims by my insurance company for any reason.

Patient Signature: ______________________________________ Date: ____________________

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and (if applicable) Medigap benefits, be made either to me or on my behalf to: **DESERT PINES REHABILITATION** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicare Services, my Medigap insurer and their agents any information needed to determine these benefits for related services.

Patient Signature: ______________________________________ Date: ____________________

VEHICLE ACCIDENT INFORMATION

Date: _____/_____/______ Patient Name: ____
(Last) (First) (Init)

Date of Accident: _____/_____/_____ Describe the accident: ____

Where you the: ❒ Driver ❒ Front passenger ❒ Rear Passenger ❒ Pedestrian ❒ Other ______________________

Model of vehicle you were in: ______________________________
Speed of your vehicle: ______________________________

Model of the other vehicle: ______________________________
Speed of the other vehicle: ______________________________

Show how the accident happened

Were you wearing your seat belt? ❒ Yes ❒ No

Did your airbag deploy? ❒ Yes ❒ No ❒ No airbag

At time of impact you were looking: ❒ Straight Ahead ❒ Ahead, but not sure ❒ Down ❒ Left ❒ Right

Did you brace yourself for the impact? ❒ Yes ❒ No

Did your head/body strike anything inside the vehicle? ❒ No ❒ Yes My ____________ struck the ______________

Were you unconscious immediately after the accident? ❒ No ❒ Yes ❒ Unsure

Did the police come to the accident site? ❒ Yes ❒ No Was a report filed? ❒ Yes ❒ No ❒ Unsure

Visible damage to your vehicle: ❒ Unknown ❒ No visible damage ❒ Minor ❒ Moderate ❒ Heavy ❒ Totaled

Visible damage to other vehicle: ❒ Unknown ❒ No visible damage ❒ Minor ❒ Moderate ❒ Heavy ❒ Totaled

Was your vehicle towed from the scene? ❒ Yes ❒ No ❒ Unsure

Did an ambulance/paramedics come to the accident site? ❒ Yes ❒ No

How did you leave the accident site? ❒ Ambulance ❒ Drove home ❒ Was driven home ❒ Was driven to hospital

Did you go to a hospital / doctor? ❒ No ❒ Yes Which one: ____________________ When: ______/_____/______
Treatments received: ❒ Exam ❒ X-rays ❒ Injection ❒ Rx prescription ❒ Released ❒ Admitted

Home treatments: ❒ None ❒ Rest ❒ Home heat pack ❒ Home cold pack ❒ OTC Meds

Are your symptoms getting worse? ❒ Yes ❒ No ❒ Staying the same

Have you missed work due to this injury? ❒ No ❒ Yes How many days? ________________________________

Mark all symptoms you have had since your injury:

❒ Headache ❒ Dizziness ❒ Blurred Vision

❒ Neck Pain ❒ Arm Pain/ Numbness ❒ Ringing in ears

❒ Mid back pain ❒ Chest/ Ribs Pain ❒ Sleep loss

❒ Low Back Pain ❒ Leg Pain/ Numbness ❒ Other_________________________

Patient Signature ____ **Date** ______/______/______

DESERT **P**INES **R**EHABILITATION
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DUTIES **U**NDER **D**URESS
LOSS **O**F **E**NJOYMENT **F**ORM

Patient Name___________________________________ Date____________________________

My **WORK STATUS** is:

☐ Working ☐ Unemployed ☐ Homemaker ☐ Not working due to pain.

Why have you continued to work?
☐ I could lose my job if I took time off.
☐ I couldn't support my family otherwise.
☐ My business could fail if I took time off.

My **FAMILY STATUS** would best be described as:

☐ Single ☐ Single with Kids. Number of children at home: _________
☐ Spouse Only ☐ Spouse and Kids. Number of children at home: _________

Activities which cause **HEAD, NECK or ARMS** pain or difficulty.

☐ Almost any movement ☐ Looking while driving
☐ Lifting/carrying with arms ☐ Getting up from lying down
☐ Reading/concentrating ☐ Remembering

Activities which cause **BACK or LEGS** pain or difficulty.

☐ All movements ☐ Twisting
☐ Standing ☐ Prolonged sitting
☐ Walking ☐ Driving/traveling
☐ Climbing stairs ☐ Getting in or out of a car
☐ Bending ☐ Getting up from sitting

GENERAL ACTIVITIES which cause pain or difficulty.

☐ Working ☐ Yard work
☐ Household chores ☐ Caring for family/children
☐ Self-care ☐ Socializing
☐ Sleeping (Hours lost:_______) ☐ Sexual activity
☐ Other:____