

PATIENT INFORMATION - HAND REHABILITATION SPECIALISTS

Name _____ Age _____ Birthdate _____
SS # _____ Marital status: single married Sex: F / M

Home address _____ City _____ Zip _____
Home # _____ Cell # _____ Email (optional) _____

Employer _____ Address _____
City _____ Zip _____ Work phone _____ ext _____

Ins. Subscriber Name: _____ Date of Birth: _____ Empl. _____

Responsible party/Insured's (if under 18, or if a third party is responsible for payment)
Name _____ Relationship to patient _____

Home address _____

Home Phone _____ Employer _____

Address _____ Work phone _____

Emergency contact _____ relationship _____

Home phone _____ Work phone _____

Name of relative who does not reside with you _____ Phone # _____

Diagnosis (condition for which you are being treated) _____

Injury/illness related to: Workers' Comp Accident Auto Accident Illness Other _____

Is this an old symptom? Yes No

Did you go to the Urgent Care/ Emergency Room for this injury? Yes No

Are you currently receiving Home Health Care? Yes No

Have you had any OT, PT, Chiropractic, or Acupuncture this year for any diagnosis? Yes No

If this is an accident or injury, are you or do you plan to pursue litigation? Yes No

Do you have an attorney? Yes No Name _____ Phone _____

Injured side right left both Date of injury / onset _____

Dominant hand (the one you write with) right left Date of surgery _____

Referring physician: _____ Doctor's office location(city) _____

Name of Nurse Case Manager/ Rehab. Nurse: _____ Phone# _____

Please read the following and sign: I hereby authorize payment of medical services rendered to me or my dependent directly to Hand Rehabilitation Specialists(HRS). I also authorize HRS to furnish my insurance company (or its representative) with full information regarding evaluation and treatment rendered to me or my dependent. A photocopy thereof shall be valid. I also consent to being examined and treated at Hand Rehabilitation Specialists. I understand that all appointments cancelled without 24 hour notice will incur a \$25.00 charge which I am responsible for and is not billable to my insurance (worker's comp patients are by law not liable for payment, though we request the courtesy of 24 hours notice.) I also understand that if I miss two appointments without prior notification, all future appointments will be cancelled and I will have to reschedule, possibly losing a preferred time slot.

Signature _____ Date _____

Please read the following and sign (except workers comp patients): I understand that my insurance company is billed as a courtesy and that I am responsible for all charges not paid by my insurance company within eight weeks after billing date, and that a 1.5% interest charge per month will be added to unpaid balances over sixty days. I also understand that therapy supplies and splints may not be covered by my insurance, and I will be responsible for payment at the time supplies are provided. I will therefore ask the therapist the cost of any supplies provided. I understand that HRS will bill my insurance for these items and reimburse me if payment is received.

Signature _____ Date _____

HAND REHABILITATION SPECIALISTS

Health History

<i>Have you ever had:</i>	<i>Circle</i>	<i>Please describe</i>
Auto accidents, prior injuries	yes no	_____
AIDS, HIV.....	yes no	_____
Arthritis/systemic diseases.....	yes no	_____
Bleeding tendency.....	yes no	_____
Blood clots, current or past (incl. phlebitis, emboli)	yes no	_____
Cancer or tumors, past or present.....	yes no	_____
Depression, anxiety or other psych. disorders	yes no	_____
Diabetes.....	yes no	_____
Epilepsy or convulsions.....	yes no	_____
Fractures/broken bones.....	yes no	_____
Head injury.....	yes no	_____
Heart problems of any sort.....	yes no	_____
Pacemaker.....	yes no	_____
Hepatitis.....	yes no	_____
High blood pressure, low blood pressure...	yes no	_____
Light-headedness, fainting, seizures.....	yes no	_____
Migraine or recent headaches	yes no	_____
Neck or back disorders.....	yes no	_____
Pain syndromes, prior or current.....	yes no	_____
Peripheral vascular disease/Raynaud's.....	yes no	_____
Pulmonary disease, incl. COPD, emphysema	yes no	_____
Recent illness, hospitalization.....	yes no	_____
Scar problems (keloids, etc).....	yes no	_____
Stroke.....	yes no	_____
Tuberculosis.....	yes no	_____
Shortness of breath.....	yes no	_____
Are you currently pregnant?.....	yes no	_____
Other health issues not listed.....	yes no	_____

SURGERIES: Please list previous surgeries and their approximate dates: _____

MEDICATIONS you are currently taking (incl. Aspirin, vitamins, herbs), incl. dose and frequency: _____

ALLERGIES: (medications, sulfur, adhesive tape, latex, etc) _____

RECREATION: activities, sports, hobbies: (incl. frequency) _____

WORK: Occupation: _____ job tasks: _____



REGARDING SCHEDULING: If you have specific times that you must make your appointments, please schedule well in advance (2-3 weeks) to assure you will get the times that you need. If you are unable to keep an appointment, please give us the courtesy of calling to inform us as soon as possible. If you are late to an appointment, we will *try* to “squeeze you in”, though this is not always possible. We suggest that all patients wash their hands at the start of each therapy session to help prevent the spread of germs. PLEASE LET US KNOW IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICE!

Signature: _____ today's date: _____