

PATIENT

First Name : _____ MI _____ Last : _____ DOB : _____ AGE : _____
 Sex : **M** **F** Social Security # : _____ Primary Phone : _____ Secondary : _____
 Address : _____ City : _____ State : _____ Zip : _____
 Responsible Party : _____ Relationship to Patient : _____
 Employer (Patient or Parent) : _____ Work Phone : _____
 Work Address : _____ City : _____ State : _____ Zip : _____
 * Emergency Contact _____ Phone : _____ Relation : _____

INSURANCE

Primary Insurance : _____ Phone : _____
 Name of Insured : _____ DOB : _____ Employer : _____
 ID # : _____ Group # : _____
 Secondary Insurance : _____ Phone : _____
 Name of Insured : _____ DOB : _____ Employer : _____
 ID # : _____ Group # : _____

ONSET

Date of Injury –or- Onset of Symptoms : _____ Surgery : **NO** **YES** _____
 How Were You Injured : _____
 Chief Complaint : _____
 Prior Treatment for this condition : **NO** **YES** _____ Where : _____ When : _____

MEDICAL HISTORY

Circle if you have any of the following

Diabetes	Blood Pressure Problems	Ulcers	Currently Pregnant : No Yes
Kidney Problems	Heart Problems	Mental Illness	Joint Replacements
Epilepsy	Arthritis	CVA or TIA	Blood clots
Lung Condition	Cancer : _____	Osteoporosis	_____

Surgeries : _____
 Allergies : **NO** **YES** _____
 Other Medical Issues or Treatments : _____
 Current Medications : See List Provided _____

ACKNOWLEDGEMENT

(If over the age of 55) I have received the “Rights of the Elderly” _____ I have received a printed copy of the HIPAA(privacy) policy _____

ARE YOU PRESENTLY RECEIVING HOME HEALTH SERVICES BY ANY AGENCY? (Circle one) **Yes **NO****
Patients who are receiving Home Health Services can not be seen in an out-patient facility while they are an active home health patient.

I acknowledge the above information is true to the best of my knowledge and give my permission for Hulsey Therapy Services, PC. to release information upon request to the referring and/or treating physician, insurance carrier, patient representative, or other entities who have direct affiliation with my medical care. I hereby authorize Hulsey Therapy Services, PC to provide evaluation and treatment in accordance with the Plan-of-Care established in conjunction with the treatment and/or referring physician. I authorize payment directly to Hulsey Therapy Services, PC.

Patient / Parent : _____ Date : _____
 or Guardian Signature