

PT OT SP

For Office Use Only:

Acct. # _____ Therapist : _____ Date : _____

Diagnosis : _____ ICD-9 Code : _____

Referring Physician : _____ Treating Physician : _____

PATIENT NAME : _____ AGE : _____ PHONE : _____

ADDRESS : _____ CITY : _____ STATE : _____ ZIP : _____ CELL # _____

DOB : _____ SSN : _____ - _____ - _____ SEX : *M F* PRIOR TREATMENT : *Yes No*

If **YES** to Prior Treatment, Where and When : _____

EMPLOYER (Patient or Parent's) : _____ PHONE : _____

WORK ADDRESS : _____ CITY : _____ STATE : _____ ZIP : _____

EMERGENCY NAME AND PHONE NUMBER : _____

INSURANCE INFORMATION : WC Medicare BC/BS Aetna Medicaid United Pvt. Pay TRC Other _____

BILLING Address : _____ Primary Insured : _____
INFO _____

Emp: _____ DOB: _____
Phone : _____ Contact Person : _____

MC # : _____ CLAIM/ID # : _____ GROUP # : _____

DATE OF INJURY/ONSET : _____ DATE OF SURGERY : _____ CHIEF COMPLAINT : _____

HOW WERE YOU INJURED : _____

MEDICAL HISTORY : *Circle if you have any of the following*

- | | | |
|-------------------|-----------------------------|----------------|
| Diabetes | Blood Pressure Problems | Ulcers |
| Kidney Problems | Heart Problems | Mental Illness |
| Epilepsy | Arthritis | Allergies |
| Lung Condition | Cancer | Osteoporosis |
| Pregnant : Yes No | Menstrual Problems : Yes No | |

OTHER MEDICAL PROBLEMS / OR TREATMENT : _____

PRESENT MEDICATIONS: _____

If over the age of 55, I have received the "Rights of the Elderly" **Yes No**

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