North Bay Therapy
1990 Popps Ferry Rd.
Biloxi, MS 39532-2105
228-385-9000

NEW PATIENT INFORMATION

PATIENT INFORMATION (CONFIDENTIAL) TODAY'S DATE:

Name:____ DOB:_______________

Address:__________________________________City:____________________State:____ Zip Code: __________

Social Security Number: _____________________________ Gender: M F Marital Status: Married Single Divorced Widowed

Home Phone: _________________ Work Phone:__________________ Cell Phone: ________________

Referring Physician:_________________________________Primary Care Physician:_______________________________________

Symptoms/Injury Date:____________________________ Accident Related: [ ]Yes [ ] No [ ] Auto [ ] Worker Comp

Emergency Contact Person:________________________ Phone: ______________________Relationship: __________________________

Have you had any Physical Therapy/Chiropractic /Home Health treatment this year? [ ] Yes [ ] No When?_________________

EMPLOYMENT INFORMATION

Employer/School: ____

Employer Address: _______________________________________Employer Phone:________________

RESPONSIBLE PARTY-(*NAME SHOWING UP ON STATEMENT*)

Name of Person Responsible for this Account: ______________________________ Relationship to Patient: ________________________

Address: _________________________________ Home Phone: ______________________________

DOB: ___________________________ Social Security #:________________________________

Insurance Information

Name of Insured: ____ Relationship to Patient: ___________________________

DOB: ________________ SS#: __________________________

Insurance Company: ______________________________ Policy/ID#: __________________________ Group#: _______________

Ins Co. Address: _________________________________ City: ______________________ State: ________ Zip: ________________

I will be paying today by Cash_________ Check __________ Credit Card__________

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____YES _____NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: ____ Relationship to Patient: ___________________________

DOB: ________________ SS#: __________________________

Insurance Company: ______________________________ Policy/ID#: __________________________ Group#: __________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay all costs of the collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I have read and understand all of the above information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I authorize the performance upon myself/dependent, procedures in the realm of Physical Therapy, for the State of Mississippi, to be performed by or under the directions of R. Keith Ganey, DPT, SCS, L/ATC. I acknowledge that the above named therapist or his assistants have given no guarantee or assurance as to the results that may be obtained from the procedures

____
Patient Signature

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PATIENT ASSIGNMENT OF BENEFITS

Patient Name:____ Date:_________________________

Insurance Company:____

Insurance Group:_______________________________________ Policy #:____________________________

Patient SS#:__________ - _______ - __________

I hereby instruct and direct, my insurance company, to pay by check made out and mailed to:

North Bay Therapy
1990 Popps Ferry Rd
Biloxi, MS 39532

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name:________________________
North Bay Therapy
1990 Popps Ferry Rd
Biloxi, MS 39532-2015

For the professional or medical expense benefits allowable, and payable under my current insurance policy, as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Acknowledgement of Privacy Practice

By signing this form, I acknowledge that I have been informed of the HIPPA Notice Of Information Practice posted at the front desk and understand it completely. I may request a coy of this form.

________________________   ____________
Signature of Patient   Date

_________________________________   ____________
Employee Signature   Date

____
Patient Signature

Date:___________ Patient Name:_____________________ Age:_____

GENERAL MEDICAL HISTORY

1. **Do you <u>CURRENTLY</u> have any of the following:**
   - ☐ cancer
   - ☐ unexplained weight loss
   - ☐ current infection/infectious disease, list____________
   - ☐ incontinence (bladder/bowel)
   - ☐ fractures/suspected fractures
   - ☐ cauda equine/progressive neurological deficit

2. **Have you had any falls in the past year?** ☐ Yes ☐ No
   a. If yes, how many? _______
   b. If yes, were you injured as a result of any of the falls? ☐ Yes ☐ No

HISTORY OF CURRENT CONDITION

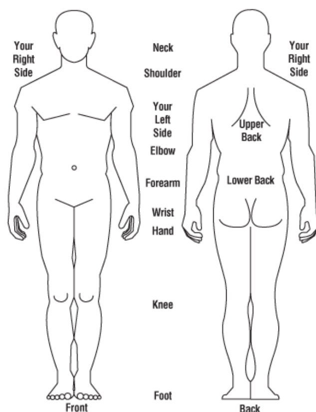
3. **Which of the following *best describes* your condition?** (if your condition is post surgical please indicate as per original condition)
   - ☐ lifting
   - ☐ a fall
   - ☐ an incident at work
   - ☐ overuse (cumulative trauma)
   - ☐ during recreation/sports ________
   - ☐ MVA (car accident) State accident occurred _____ Driver/Passenger if MVA (circle one)
   - ☐ degenerative process
   - ☐ unknown
   - ☐ other_____________

∗ **If injury, please indicate the date your injury took place?** (Specific date if possible) _____/_____/_____

∗ **Surgery Date if applicable**_____/_____/_____

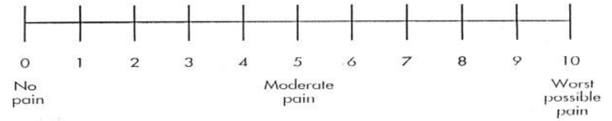
4. **Nature of primary complaint** (check all that apply):
   - ☐ pain
   - ☐ aching
   - ☐ burning
   - ☐ throbbing
   - ☐ numbness/tingling
   - ☐ constant
   - ☐ weakness
   - ☐ intermittent
   - ☐ sharp
   - ☐ dull
   - ☐ other_________

Using the key, please indicate on the body diagram where your symptoms are located:
X = Pain O = Tingling // = Numbness



Attention PATIENTS: Please complete this form in its entirety and sign, date, and provide your return appointment date for the doctor whom referred you to us.

Place an "**X**" on the line below indicating your pain at its lowest and highest levels.



5. **Please circle (R) if the activity RELIEVES your pain or circle (A) if the activity AGGRAVATES your pain:**
   1. Sitting (R) (A)
   2. Rest (R) (A)
   3. Exercise (R) (A)
   4. Heat (R) (A)
   5. Standing (R) (A)
   6. Coughing/Sneezing (R) (A)
   7. Wearing a Splint/Brace (R) (A)
   8. Cold (R) (A)
   9. Walking (R) (A)
   10. Stretching (R) (A)
   11. Lying Down (R) (A)
   12. Massage (R) (A)

6. **Does the pain wake you at night?** ☐ Yes ☐ No
   If yes, is it present:
   ☐ while lying still ☐ while changing positions ☐ both

7. **Do you have pain/stiffness getting out of bed in the morning?** ☐ Yes ☐ No

7. **Since your symptoms began have you had:** ☐ None
   - ☐ fever/ chills/ nausea/ vomiting
   - ☐ any numbness in genital/anal area
   - ☐ dizziness/ fainting
   - ☐ change in vision/ hearing/ speech
   - ☐ weakness
   - ☐ headaches
   - ☐ other:________________________________

8. **Treatments previously received for this condition?**
   - ☐ None
   - ☐ medication
   - ☐ Chiropractic
   - ☐ Physical Therapy
   - ☐ massage
   - ☐ hospitalization
   - ☐ home health (list dates)_________
   - ☐ bracing/taping
   - ☐ surgery (dates)___________
   - ☐ casting/immobilization
   - ☐ TENS unit
   - ☐ injections/acupuncture
   - ☐ other___________________
   - ☐ speech/occupational therapy (list dates)_____________

9. **Please check any other health care providers you are <u>currently</u> seeing for this condition:** ☐ None
   - ☐ MD________________
   - ☐ Podiatrist
   - ☐ Physical Therapist
   - ☐ Dentist
   - ☐ Chiropractor

10. **Please check if you have had any of the following?**
    ☐ None ☐ EMG ☐ X-Rays ☐ MRI ☐ CT Scan

GENERAL HEALTH

How would you rate your overall health?
☐ excellent ☐ good ☐ average ☐ fair ☐ poor

If female, are you pregnant? ☐ no ☐ yes, due: ___/___/___

Apart from your daily activities do you exercise?
☐ 5 + days/wk ☐ 3-4 days/wk ☐ 1-2 days/wk ☐ occasionally
☐ rare

Do you smoke? ☐ no ☐ yes ☐ past smoker

MEDICATIONS

Please list ALL prescriptions, over the counter medications, herbal supplement, and vitamins you are currently taking with dosage, frequency, and route of administration (oral, injection, inhalation, etc.): ☐ see attached list

Name	Dosage	Frequency	Route of Administration

PAST/CURRENT MEDICAL HISTORY

Have you ever <u>had/been diagnosed with</u> any of the following conditions?

☐ none
☐ high blood pressure
☐ heart problems
☐ metal implants
☐ pacemaker
☐ heart defibrillator
☐ stroke
☐ HIV
☐ kidney problems
☐ thyroid problems
☐ epilepsy/seizure/dizziness
☐ Diabetes
☐ circular/vascular problems
☐ list any other surgeries_________________________________
____

☐ chemical dependency
☐ depression
☐ lung problems/ asthma
☐ blood disorder/ anemia
☐ multiple sclerosis
☐ allergies
☐ stomach problems
☐ Parkinson's
☐ head injury
☐ Arthritis
☐ spine problems
☐ spine surgery

PREVIOUS FUNCTIONAL LEVEL (before injury)

☐ **Independent in all activities** (work, home, recreation)

Self Care

☐ Independent (bathing, toileting, dressing, etc)
☐ Difficulty in performing self care activities
☐ Need assistance with self care activities
☐ Difficulty in performing household chores

Social/Recreational/Leisure

☐ Limited in_________________________

WORK HISTORY (Current or Most Recent Job)

<u>CURRENT</u> working status:

☐ full-time
☐ not working
☐ permanent disability
☐ part-time
☐ out on leave
☐ temp. disability
☐ retired
☐ modified duties

If retired, permanently disabled, or unemployed, skip the sections below.

Physical activities at work:

☐ sitting
☐ phone use
☐ heavy lifting
☐ crawling
☐ standing
☐ repetitive lifting
☐ walking
☐ heavy equipment operation
☐ computer use
☐ driving
☐ bending

<u>If not performing your normal activities at work</u>, do you plan to return to your previous activity level? ☐ Yes ☐ No

<u>If you were injured on the job</u>, please describe how the incident occurred.

____
____
____
____
____
____.

Referral Source (MD) follow-up appointment:
______/______/______.

Patient/Guardian Signature:
____