7010 Hodgson Memorial Dr. Savannah, GA 31406

PATIENT INFORMATION FORM

First Name: _____MI_____Last Name: _____

Birthdate: _____ Social Security#: _____

Mailing Address: _____

City, State, ZIP _____ Home phone: _____

Email: _____ Cell phone: _____

Patient Status: (please circle) Single Married Widowed Divorced Separated Partnered

Health Insurance Company: _____

Insurance ID #: _____Insurance group: _____

Insurance Subscriber Name: _____ Subscriber Birthdate: _____

Relation to Insurance subscriber: _____

Emergency Contact Person: _____

Relationship: _____ Emergency Contact Phone #: _____

Referring Doctor: _____ Diagnosis: _____

Reason for Therapy: (please circle) Home Related Work Related Auto Related Other

If Auto related, Date of Auto Accident: _____ Location of Accident: _____

If your injury is a result of an Auto Accident you are responsible to pay for services and then collect from the Auto Carrier. We will file your Med-Pay Medical Insurance as a courtesy.

If post-surgery, Type of Surgery: _____ Date of Surgery: _____

Next Referring Doctor Appointment: _____

LEDESMA
SPORTS MEDICINE

ACCOUNTING PRINCIPALS

AS A COURTESY, WE WILL BILL YOUR INSURANCE IF YOU PROVIDE US WITH THE APPROPRIATE INFORMATION. PLEASE ALLOW US TO MAKE A COPY OF YOUR INSURANCE CARD FOR YOUR FILE. WE ADVISE YOU TO CONTACT YOUR INSURANCE COMPANY AND INQUIRE SPECIFICALLY ABOUT YOUR PHYSICAL THERAPY BENEFITS.

ACCOUNTS THAT ARE SENT TO COLLECTIONS ARE SUBJECT TO A CHARGE OF UP TO 33% OF THE AMOUNT OWED. IT IS IMPORTANT THAT YOU UNDERSTAND THAT YOU ARE PERSONALLY RESPONSIBLE FOR ALL SERVICES RENDERED AT LEDESMA SPORTS MEDICINE AND THAT ALL FEES ARE CHARGED DIRECTLY TO YOU.

With my signature, I consent to receiving physical therapy treatment. I also hereby authorize the release of medical information necessary to process the claim and authorize the payment of medical benefits to Ledesma Sports Medicine.

Signature: _____ Date: _____
If not signed by patient, please indicate relationship to the patient (i.e. Spouse, Mother…)
Relationship: _____

Witnessed by: _____Date: _____
(Ledesma Sports Medicine Representative)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received a copy of Ledesma Sports Medicine Notice of Privacy Practices, explaining how my Protected Health Information (PHI) may be used and shared as permitted by law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my Protected Health Information (PHI). Further, I permit a copy of this permission to be used in place of the original.

Signature: _____ Date: _____

If not signed by patient, please indicate relationship to the patient (i.e. Spouse)
Relationship: _____

Witnessed by: _____ Date: _____
(Ledesma Sports Medicine Representative)

LEDESMA
SPORTS MEDICINE

DIAGNOSIS & TREATMENT

I do _____do not _____ want you to discuss my diagnosis and treatment with family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

_____

Patient name:_____ Date of Birth: _____

RELEASE OF MEDICAL RECORDS

I am hereby authorizing Ledesma Sports Medicine to request on my behalf, Medical Records and/ or Health Information from past/ current physicians.
I understand that I may revoke this authorization, in writing, at any time. Disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization. Without my written revocation, the authorization will automatically expire upon satisfaction of the need for disclosure.

Patient/ Guardian Signature _____

Relation to Patient _____

Date _____

LEDESMA
SPORTS MEDICINE

PATIENT MEDICAL HISTORY

To better serve your needs and understand your medical condition, please answer the following questions. Thank you.

***Have you or any immediate family members ever had the following medical conditions*? Please specify**					
	YOU		FAMILY MEMBER		RELATIONSHIP
Cancer	Yes	No	Yes	No	
Diabetes	Yes	No	Yes	No	
High Blood Pressure	Yes	No	Yes	No	
Heart Disease/Heart Attack	Yes	No	Yes	No	
Arthritis/Osteoarthritis	Yes	No	Yes	No	
Angina/Chest Pain	Yes	No	Yes	No	
Stroke	Yes	No	Yes	No	
Neurological Disorders (Parkinson's, MS…)	Yes	No	Yes	No	
Osteoporosis	Yes	No	Yes	No	

Do you have a history of:			***Are you:***		
Thyroid?	Yes	No	Sensitive to ice?	Yes	No
Allergies/Asthma?	Yes	No	Sensitive to heat?	Yes	No
Headaches?	Yes	No	Sensitive to light?	Yes	No
Bronchitis?	Yes	No			
Kidney disease/problems?	Yes	No	Pregnant	Yes	No
Rheumatic fever?	Yes	No	Depressed?	Yes	No
Ulcers?	Yes	No	Under stress	Yes	No
Sexually Transmitted Disease?	Yes	No			
HIV?	Yes	No	***Do you have problems with any of the following:***		
Seizures?	Yes	No			
Nervous Disorders? (anxiety, depression…)	Yes	No	Hearing?	Yes	No
Hernia?	Yes	No	Speech?	Yes	No
Metal Implants?	Yes	No	Energy?	Yes	No
Pacemaker?	Yes	No	Vision?	Yes	No
Dizziness?	Yes	No	Communication?	Yes	No
Balance problems?	Yes	No	Focusing?	Yes	No

LEDESMA
SPORTS MEDICINE

***Date of last medical exam**: _____*

In the past 3 months, have you had or did you experience any of the following?		
A change in your health	Yes	No
Nausea/vomiting	Yes	No
Fever/chills/sweats	Yes	No
Unexplained weight change	Yes	No
Numbness or tingling	Yes	No
Changes in appetite	Yes	No
Difficulty swallowing	Yes	No
Changes in bowel/bladder	Yes	No
Shortness of breath	Yes	No
Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No

Do you or have you ever smoked? Yes or No

If yes, how many cigarettes a day? _____ for how many years? _____

Do you drink alcohol? Yes or No If yes, how many per week? _____

Date of Injury or Onset of Symptoms: _____

***Since the onset of your symptoms are you getting**:* (check one)

□ better □ worse □ no change

***How do you sleep at night**?*

□ fine □ with moderate difficulty □ only with medications

Please list anything you may feel is important to your visit here today: _____

_____

_____

List any medications you are currently taking: _____

_____

_____

List recent diagnostic studies (X-rays, MRI, CT scan…): _____

_____

Please list surgeries you have had and dates (if possible): _____

_____

_____

Have you received any home health care services (PT, OT, etc…) in the past 30 days Yes □ No □

Have you had any physical therapy this calendar year beginning January 1st? Yes □ No □

Patient Signature: _____ Date: _____