PATIENT INFORMATION FORM

Patient Name (Last, First, MI)	Date of Birth	Referring Physician	Today's Date

Address (Street-City-State-Zip)	Home Phone	Work Phone

Employer Name	Contact Person	Social Security Number

Email Address:	Medicare Number

Employers Address (Street-City-State-Zip)	Is injury job related?	Date of Onset	Diagnosis

Spouse's Name (Last, First, MI)	D/O/B	Social Security Number	Spouse's work phone
			( ) -

Have you received any physical, occupational, or speech therapy from <u>any other</u> <u>outpatient facility</u> since January 1, 2014? _____Yes _____No

Are you currently receiving any Home Health services? _____Yes _____No

INSURANCE INFORMATION

Primary Insurance Company	Address (Street-City-State-Zip)	Phone
		(____) ______-__________

Name of Insured	Place of employment	Relationship	I.D. Number	Group No.

Secondary Insurance Company	Address (Street-City-State-Zip)	Phone
		(____) _______-_______

Name of Insured	Relationship	I.D. Number	Group #

AUTO INSURANCE INFORMATION (IF APPLICABLE)

Auto Insurance Company	Group or policy #	Insured's SS#

Address of Insurance Company (Street-City-State-Zip)	Phone	Name of Insured
	( ) ___-_______	

Adverse Auto Insurance Company	Group or policy #	Insured's SS#

Address of Insurance Company (Street-City-State-Zip)	Phone	Name of Insured
	( ) ____-______	

Attorney Information (If Applicable)

Attorney's Name	Address (Street-City-State-Zip)	Telephone

(OVER)

AUTHORIZATION, AGREEMENTS AND ACKNOWLEDGEMENTS for Rehabilitation Services

CONSENT FOR TREATMENT I hereby authorize Azer Clinic to carry out all rehabilitation procedures, techniques, and teaching as approved by my physician.

RELEASE OF INFORMATION I consent to the release of my clinical records to be reviewed by designated legal or authorized representatives of Medicare, Blue Cross, HMO, Worker's Compensation and/or a private insurance company as appropriate. In addition, I authorize the records to be reviewed for any necessary State, Federal, or internal audits and for transfer of pertinent medical information to recognized professional, social and health care providers. A photocopy of this authorization shall be considered valid for the duration of this claim, but will not exceed one year from the date signed.

MEDICAL INSURANCE BENEFITS STATEMENT I certify the information given by me is correct. I request that payment of authorized benefits be made to Azer Clinic on my behalf. I understand that I am financially responsible for charges not covered by this authorization (non-covered services and supplies). I authorize any holder of medical information about me to be released to the Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) and its agents/my insurer/any third party payer and its agents any information needed to determine these benefits or the benefits payable for related services.

ACKNOWLEDGEMENTS It is my choice to receive rehabilitation services at Azer Clinic. I understand I have a right to receive a copy of this authorization at my request.

I acknowledge my receipt of Azer Rehab Systems Notice of Privacy Practices effective April 14, 2003 on the date stated below.

1. Please list family members, significant others, or anyone else, if any, whom we may inform about your general medical condition and your diagnosis.
   ____
   ____
   ____

2. Please print the telephone number, if any, where you want to receive calls about your appointments, or other health care information **if other than your home phone number:** (____) _____-_______.

3. Can confidential messages (i.e. Appointment reminders) be left on your home answering machine or voicemail? YES __________ NO__________

______________________________ ______________________________

Patient Name- PRINT Date

____

Patient Name- SIGNATURE

If patient is unable to sign:

______________________________ ______________________________

Signature of Responsible Person Relationship to patient Date

Explanation of patient's inability to sign ______________________________

To help us serve you better Please take a moment and tell us how you heard about Azer Clinic.

Check all that apply:

____ Radio
____ Television
____ Newspaper
____ Phonebook
____ Advertisement on City Bus
_____ Billboard
_____ Your doctor referred you here
_____ A friend/relative referred you here
_____ Azer Clinic was listed on the script given to you by your physician
_____ Other (Please list) ______________________________
____You chose to have therapy here based on the recommendation of an Azer Employee

Name of employee______________________________

872 West Dayton Street, Galesburg, IL 61401
Phone: (309) 344-3400 Fax: (309) 344-5040

Past Medical History Questionnaire

This questionnaire is designed to assist your therapist in determining your past medical history which may have an impact on the care you receive in this clinic. It is therefore in your best interest to answer it accurately.

Do you have or have you ever had any of the following:

Problem or condition	Yes	No	Problem or condition	Yes	No
High Blood Pressure?			Hypersensitivity to heat ?		
Heart Disease ?			Hypersensitivity to cold ?		
Lung Disease ?			Loss of sensation in any body area ?		
Tuberculosis ?			Skin disorders (eczema, psoriasis) ?		
Diabetes ?			Dizzy spells (with or without fainting) ?		
Epilepsy ?			Claustrophobia ?		
Stroke ?			Osteoporosis (brittle bones) ?		
Rheumatic fever ?			Do you have a pacemaker ?		
Cancer ?			Do you have any metal implants, pins or plates ?		
Temporomandibular joint (TMJ) problems ?			Do you have a hearing aid ?		
Vein or Artery problems ?			Are you currently under going any other medical treatments or therapies (chemotherapy) ?		
Blood clotting problems ?			Do you presently have any contagious disease ?		

To better serve you, we would like to ask you four questions in reference to your rehabilitation of your current injury or illness. Your answers will be kept private and confidential. If you'd like to speak privately with your therapist about your answers, please tell the receptionist. Thank you.

1. Do you feel you have a good understanding of your diagnosis?
2. Do you understand your prognosis (anticipated recovery rate and status) of your injury or illness?
3. Do you feel severely depressed?
4. Do you feel you have adequate family or friend support to help you as you undergo rehabilitation?

(OVER)

Please list recent surgeries or surgeries we should be aware of:

SURGERY	APPROXIMATE DATE
1.	
2.	
3.	

Please list medications that you are presently taking.
(You may also bring in a list, which we will copy)

1.
2.
3.
4.
5.

Patient Signature: ______________________________ **Date:** ______________