Welcome to GoRehab. We ask that you completely fill out the attached forms. We are not asking for any information we don't need so please be as thorough as possible. If you have any questions, please do not hesitate to ask one of our staff members as they are always happy to help.

Last Name: ______________________________ **DOB:** ______________________________

First Name: ______________________________ **SSN:** ______________________________

Home Address: ____
Street **City** **State** **Zip Code**

Phone Number:______________________________ **Email:** ______________________________

Marital Status: (circle one) Single Married Separated Divorced

Emergency Contact: ______________________________ **Phone:** ______________________________

Employer: ______________________________ **Work Phone:** ______________________________

Employer Address: ____
Street **City** **State** **Zip Code**

Occupation: ______________________________ **Are you currently working?** Yes No

Referring Physician or Primary Care Physician: ____

Phone Number: ______________________________

Our government is now requiring all practices to anonymously report patient statistics. Please answer the following questions. Please be assured that patient privacy is our top priority!

Race: (circle one) White Black or African American American Indian or Alaska Native Asian
Native Pacific or Other Pacific Islander Other Race

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino Not Providing

Language: (circle one) English Spanish Chinese French German Italian Japanese Portuguese Other

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MEDICATION INFO

Patient Name: ____ DOB: ________________________________

Please list any medications you are currently taking: ____

____

____

____

Allergies: (circle any that apply) NSAIDS (Ibuprophen/Aleve) Aspirin Macrolides (Erthromycins)

Penicillins Tetracyclines Sulfa Drugs

Other: ____

Do you or have you ever smoked cigarettes? Never Smoked Former Smoker Current Smoker

Do you consume alcohol? Never Occasionally Often

Height: __________________________ Weight: __________________________________

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INSURANCE INFORMATION

Patient Name: ____ DOB: ________________________________

Primary --

Insurance Name: ____

Insurance Address: ____

Insurance Phone: __________________________________

Insurance ID#: __________________________________ Group#: ________________________________

Relationship to Patient: (circle one) Self Spouse Dependent

Secondary --

Insurance Name: ____

Insurance Address: ____

Insurance Phone: __________________________________

Insurance ID#: __________________________________ Group#: ________________________________

Relationship to Patient: (circle one) Self Spouse Dependent

Workers' Compensation [Please also provide your private insurance information above]--------------------------

WC Insurance Carrier: ____

Carrier Case#: ____

Date of Injury: __________________________________ WCB#: ________________________________

Injured Body Part(s): ____

Adjuster Name: __________________________________ Phone#: ________________________________

No Fault [Please also provide your private insurance information above]---

NF Insurance Carrier: ____

Claim#: ____

Date of Accident: __________________________________

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Patient Name: ____ **DOB:** _________________________________

Chief Complaint: ____

How and where were you injured:

____

____

Where is the pain? Back Neck Other: __________________________________

Do you have a prior history of neck or back pain? Yes No

Treatments you have received to date:

[ ] Physical Therapy
[ ] Chiropractic Care
[ ] Acupuncture
[ ] Epidural Injections
[ ] Trigger Point Injections
[ ] Diagnostic Imaging

Did another healthcare provider treat this injury including hospitalization and/or surgery? Yes No

If yes, how/when: ____

____

Have you had any of the following: (circle any that apply)

Numbness/tingling	Swelling	Pain	Weakness
Stiffness	Dizziness	Faintness	Swaying/Tilting
Difficulty Walking	Double Vision	Headaches	Loss of Balance
Ringing in the Ears	Chest Pains	Other: ________________________	

Nature of Injury/Illness: (circle any that apply)

Abrasion	Amputation	Avulsion	Bite
Needle Stick	Contusion/Hematoma	Hernia	Fracture
Infectious Disease	Inhalation Exposure	Laceration	Burn
Poisoning/Toxic Effects	Dislocation	Sprain/Strain	Puncture Wound

Other: ____

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Are your symptoms affected or brought on by any of the following? (circle any that apply)

Change in Position	Rapid Head Movement	Walking on Uneven Surfaces
Smoking	Alcohol	Climbing Stairs or Ladder
Watching Moving Objects	Standing up	Walking in dark or dimly lit room
Traveling in a car, airplane, or boat		Coughing, Sneezing, Straining

Do you use a cane and/or walker? Yes No

<u>Motor Vehicle Accident Related History</u>
(skip to next section if not applicable)

Were you the:	Driver	Passenger sitting in the front
	Passenger sitting in the rear left	Passenger sitting in the rear right
	Pedestrian	

Were you wearing a seat belt? Yes No

Did you lose consciousness? Yes No

Was the car stopped or moving? Stopped Moving

What type of vehicle were you in?	Car	Truck	Van	Bus
	Motorcycle	Taxi		
What type of vehicle were you struck by?	Car	Truck	Van	Bus
	Motorcycle	Taxi		

Any prior motor vehicle accidents? Yes No

Medical History

Circle all that apply:

Heart Disease High Blood Pressure Ulcers Epilepsy Diabetes

Other: ____

Surgical History: Cardiac Stents Leg Stents Open Heart Surgery

Previous Fractures: ____

Previous Surgeries: ____

Serious Illnesses: ____

Any Unusual Medical History:

____

____

Female Patients Only: Is there any possibility you may be pregnant? Yes No

Family History

Has any member of your family ever had any of the following:

	Which Family Member:	Age Diagnosed:
Cancer [describe type]	________________________	________________________
Hypertension	________________________	________________________
Heart Disease	________________________	________________________
Diabetes	________________________	________________________
Strokes	________________________	________________________
Mental Disease	________________________	________________________
Drug/Alcohol Addiction	________________________	________________________
Glaucoma	________________________	________________________
Bleeding Disease	________________________	________________________
Other	________________________	________________________

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HIPAA Privacy Rule of Patient Authorization Agreement Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

____ ______________________________

Signature of Patient or Legal Representative Witness: Date:

____

Patient Name:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Grewal Orthopedic & Spine Care (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

____ ______________________________

Signature of Patient or Legal Guardian Date

____

Patient Name:

Consent for Treatment

I hereby give my permission for Grewal Orthopedic & Spine Care to give me medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.
I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

____ ______________________________

Signature of Patient or Legal Guardian Date

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