

**ATHENS PHYSICAL THERAPY
 ATHENS NEURO AND BALANCE REHABILITATION
 PHYSICIANS BACK AND NECK CLINIC
 BETTER BONE CLINIC
 CHRISTOPHER E. DOERR, D.O., P.C.**

GENERAL MEDICAL HISTORY FORM

Patient Name _____ Date of Birth _____
 Age _____ Male/Female _____ Height _____ Weight _____ Right / Left Handed _____
 Name of Referring Physician _____ Primary Care Physician _____

My signature below confirms that the information provided on this document is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

DEMOGRAPHIC DATA

LANGUAGE	RACE	ETHNICITY	EMAIL ADDRESS
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Refuse to answer	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refuse to answer	<input type="checkbox"/> Hispanic Origin (Spanish) <input type="checkbox"/> Non- Hispanic Origin <input type="checkbox"/> Refuse to answer	 By providing your email address you are consenting to use of the Patient Portal

PREFERRED PHARMACY

Pharmacy name	Address/Location	Phone number	Your signature and Date

MEDICATIONS

LIST ALL MEDICATIONS CURRENTLY TAKEN INCLUDING OVER-THE-COUNTER / HERBAL / DIET SUPPLEMENTS

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.

Patient Name _____ Date of Birth _____

ALLERGIES

Please list any medications you are allergic to and type of reaction: _____

Are you allergic to anything else? NO YES _____

PAST MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

<input type="checkbox"/> Acid reflux or Hiatal hernia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Chronic Lung disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Menopausal
<input type="checkbox"/> Bladder problems	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Bleeding/bruising disorder	<input type="checkbox"/> Heart Attack/Disease	<input type="checkbox"/> Osteoporosis/Osteopenia
<input type="checkbox"/> Blood clots in legs or lungs	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Brain injury	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer (what kind)	<input type="checkbox"/> Hypoglycemia (low blood sugar)	<input type="checkbox"/> Depression/Psychological problems
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Inflammatory Bowel/Malabsorption disease	<input type="checkbox"/> Hyperparathyroidism
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Irritable Bowel syndrome	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> TMJ	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Spinal Cord injury	<input type="checkbox"/> Vitamin D deficiency
<input type="checkbox"/> Paget's Disease/Rickets/Osteomalacia		

PLEASE CHECK ALL THE SURGERIES AND PROCEDURES YOU HAVE HAD:

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hernia (hiatal, abdomen or groin)	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Cholecystectomy (gallbladder removal)	<input type="checkbox"/> C-section	<input type="checkbox"/> Joint replacement Specify:
<input type="checkbox"/> Metal implants	<input type="checkbox"/> Back or neck surgery Specify:	<input type="checkbox"/> Bone density test
<input type="checkbox"/> Cardiac catheterization	<input type="checkbox"/> Breast implants or reduction surgery	<input type="checkbox"/> Other surgery
<input type="checkbox"/> Exercise stress test	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pacemaker

Patient Name _____ Date of Birth _____

REVIEW OF SYSTEMS

CHECK IF YOU HAVE A HISTORY OF:

<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Swollen lymph nodes	<input type="checkbox"/> Frequent cough (once a day or more)
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Coughing up phlegm or mucus daily
<input type="checkbox"/> Urine leakage	<input type="checkbox"/> Profuse sweating at night
<input type="checkbox"/> Change in stool color	<input type="checkbox"/> Frequent vomiting
<input type="checkbox"/> Frequent urination at night	<input type="checkbox"/> Balance problems
<input type="checkbox"/> Problems with memory/concentration	<input type="checkbox"/> Hard of Hearing
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Coordination problems
<input type="checkbox"/> Shortness of breath at rest	<input type="checkbox"/> Blurred or Double vision
<input type="checkbox"/> Shortness of breath with little exertion	<input type="checkbox"/> Joint pain/swelling (other than your spine)
<input type="checkbox"/> Shortness of breath while lying flat	<input type="checkbox"/> Muscle pain/spasm
<input type="checkbox"/> Swelling of the feet, ankles and/or legs	<input type="checkbox"/> Numbness/tingling of hand, arm, leg or foot
<input type="checkbox"/> Leg pain with prolonged walking	<input type="checkbox"/> Weakness of leg or arm
<input type="checkbox"/> Recent fractures	<input type="checkbox"/> If you are female, any chance you are pregnant?
<input type="checkbox"/> Rash	<input type="checkbox"/> Sensitivity to chemicals
<input type="checkbox"/> Excessively tired	<input type="checkbox"/> Ringing in your ears
<input type="checkbox"/> Bowel or bladder abnormalities	<input type="checkbox"/> Frequent headache
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Constipation	<input type="checkbox"/> Emotionally traumatic event
<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Anxiety attacks
<input type="checkbox"/> Hyperventilating spells	<input type="checkbox"/> Weight gain of _____ pounds in last 6 months
<input type="checkbox"/> Females: painful menstrual periods	<input type="checkbox"/> Weight loss of _____ pounds in last 6 months

Is there any information that is not already included in this form that you feel is important for us to know regarding your health? _____

FAMILY HISTORY

ARE THERE ANY DISEASES THAT RUN IN YOUR FAMILY? PLEASE LIST HEALTH PROBLEMS OR CAUSE OF DEATH

Father	Age
Mother	Age
Sibling	Age
Sibling	Age
Sibling	Age

Patient Name _____ Date of Birth _____

SOCIAL HISTORY

CURRENT WORK STATUS:

Working:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> RETIRED	Current or Previous Occupation:
Disabled:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Reason for disability:
Medical Leave	<input type="checkbox"/> YES <input type="checkbox"/> NO	Who took you out of work?
		Last Day Worked?

CURRENT MARITAL STATUS:

Single Married Divorced Widowed

If married, what is the name of your spouse/partner? _____

DOES YOUR HOME HAVE ANY OF THE FOLLOWING?

Stairs without railing Stairs with railing Ramps
 Uneven terrain or obstacles Assistive devices Elevator

WITH WHOM DO YOU LIVE?

Alone Spouse/Partner Children Parents Other: _____

DO YOU HAVE CHILDREN? NO YES Ages _____

DO YOU SMOKE? NO, never NO, but I used to Start date: _____ Quit date: _____

YES Form of tobacco? _____ Packs/day? _____ Are you interested in quitting? NO YES

DO YOU DRINK ALCOHOL? NO, never NO, but I used to YES

If YES, how often and how much? Daily Weekly Monthly Yearly Number of drinks _____

DO YOU USE RECREATIONAL DRUGS? NO YES If yes, what substance(s) _____

DO YOU FEEL YOU ARE DEPENDENT ON DRUGS OR ALCOHOL? NO YES

DO YOU EXERCISE REGULARLY? NO YES _____ times per week Type of exercise _____

HAVE YOU HAD A FLU SHOT IN THE LAST 12 MONTHS? YES NO

IF OVER 65 YRS OLD, HAVE YOU HAD THE PNEUMOCOCCAL VACCINE? YES NO

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: _____

- 1. Consent:** By signing this form, I consent to treatment necessary or desirable for the patient named above. **I understand that if my insurance requires a referral from my Primary Care Physician, it is my responsibility to confirm that my referral is current and in effect before I arrive for my appointment.**
- 2. Covered Benefits:** As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered service as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elects to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. **IT IS NOT A GUARANTEE OF PAYMENT.** Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.
- 3. Co-payments:** Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa, Master Card, Discover, American Express and Care Credit).
- 4. Attendance Policy:** Your therapist allocates a specific amount of time for your appointment in order to meet the needs of your rehabilitation program. We understand there are times when you must miss an appointment, but request that you give us **24-HOUR NOTICE**. We charge **\$50.00 for Dr. Doerr and \$25.00 for therapy cancellations when less than 24 hour notice as well as missed appointments.**
- 5. Returned checks:** There is a fee of **\$30.00** for each returned check.
- 6. Children:** Unsupervised children are NOT allowed in the waiting area, rehabilitation areas or examination rooms.
- 7. Medication refills:** Please allow 1-2 working days for prescription renewals. Refills may not be available on Fridays.
- 8. Completion of forms:** There is a fee for special forms you may need us to complete. Please check with the staff regarding the charges.

I have read the above statements. It is my understanding that I am financially responsible to APT/ANBR/PBNC for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to APT/ANBR/PBNC. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

Patient or legal representative signature _____ **Date** _____

**ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.**

HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize APT/ANBR/PBNC to disclose my protected health information to the following person(s):

Name	Relationship	Phone number

May we leave confidential clinical information on your answering machine? YES NO

I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

I have received and read the HIPAA privacy policy of Athens Physical Therapy/Athens Neuro and Balance Rehabilitation/ Better Bone Clinic and Physicians Back and Neck Clinic.

This release shall remain in force until revoked in writing by the patient or representative signing this form. If you wish to revoke authorization, please submit your request in writing and mail or hand deliver to 108 Park Ave. Athens GA 30601.

Patient or legal representative signature _____ **Date** _____

**ATHENS PHYSICAL THERAPY
 ATHENS NEURO AND BALANCE REHABILITATION
 PHYSICIANS BACK AND NECK CLINIC
 BETTER BONE CLINIC
 CHRISTOPHER E. DOERR, D.O., P.C.**

MEDICAL RECORDS AND IMAGING RELEASE AUTHORIZATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

PLEASE RELEASE TO:

ATHENS PHYSICAL THERAPY/PHYSICIANS BACK AND NECK CLINIC/BETTER BONE CLINIC	ATHENS PHYSICAL THERAPY	ATHENS NEURO AND BALANCE REHABILITATION
108 PARK AVENUE ATHENS, GA 30601	12605 AUGUSTA ROAD LAVONIA, GA 30553	1088 BAXTER STREET, SUITE C ATHENS, GA 30606
PHONE: 706-546-1333	PHONE: 706-356-1333	PHONE: 706-549-7400
FAX: 706-546-5807	FAX: 706-356-1433	FAX: 706-769-7399

This form is used to request previous films (MRIs, X-rays, CTs, bone scans, etc.) lab work, diagnostic studies and medical records from previous providers.

I authorize PBNC/APT/ANBR to release any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care.

This authorization shall remain in force until revoked in writing by the patient or representative signing this form. If you wish to revoke authorization, please submit your request in writing and mail or hand deliver to one of the locations listed above.

PATIENT SIGNATURE: _____ DATE: _____