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

Today's Date: _____

GENERAL MEDICAL HISTORY FORM

Patient Name_____ Date of Birth_____ Social Security #_____

Age_____ Male/Female Height___'_____" Weight_____lbs 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: _____

Parent/Guardian's Signature: _____

DEMOGRAPHIC DATA

LANGUAGE	**RACE**	**ETHNICITY**	**EMAIL ADDRESS**
□ English □ Spanish □ Other □ Declined	□ American Indian/Alaska Native □ Black/African American □ Native Hawaiian/other Pacific Islander □ White □ Asian □ Other Race □ Declined to Specify	□ Hispanic Origin (Spanish) □ Non- Hispanic Origin □ Declined to Specify	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

	Name	Strength (mg)	Times per day
1			
2			
3			
4			
5			
6			
7			
8			

(Continue medication list on next page)

Patient Name_____ Date of Birth_____

Continued medication list:

	Name	Strength (mg)	Times per day
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

ALLERGIES

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

_____

Are you allergic to anything else? □ NO □ YES_____

PAST MEDICAL HISTORY

PLEASE CHECK ALL THE SURGERIES AND PROCEDURES YOU HAVE HAD:

□ Appendectomy	□ Hernia (hiatal, abdomen or groin)	□ Hysterectomy
□ Cholecystectomy (gallbladder removal)	□ Breast implants or reduction surgery	□ Cardiac catherization □ Kyphoplasty
□ Metal implants	□ C-section	□ Bone density test (DXA scan)
□ Exercise stress test	□ Heart Surgery	□ Pacemaker
□ Back or neck surgery Specify:	□ Joint replacement Specify:	□ Gastric bypass or sleeve □ Other surgery

Patient Name_____ Date of Birth_____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

□ Acid reflux or Hiatal hernia	□ Fractures type:_____ _____	□ Migraine Headache	
□ Anemia		□ Multiple Sclerosis	
□ Arthritis (choose below) __ wear and tear (osteoarthritis) __ autoimmune (rheumatoid, lupus, psoriatic)	□ GERD (reflux)	□ Osteopenia	Date of latest DXA:
	□ Gluten sensitivity	□ Osteoporosis	
□ Asthma	□ Gout		
□ Balance problem	□ Heart Attack/Disease	□ Paget's Disease/Rickets/ Osteomalacia	
□ Bladder problems	□ High Blood Pressure	□ Parkinson's Disease	
□ Bleeding/bruising disorder	□ Hyperparathyroidism	□ Prostate problems	
□ Blood clots in legs or lungs	□ Hyperthyroidism (overactive thyroid)	□ Psychological problems	
□ Brain injury	□ Hypothyroidism (low thyroid)	□ Seizures	
□ Cancer type:_____	□ Hypoglycemia (low blood sugar)	□ Spinal Cord injury	
□ Carpal Tunnel Syndrome	□ Inflammatory Bowel/ Malabsorption disease	□ Stomach Ulcer	
□ Chronic Lung disease	□ Irregular Heartbeat	□ Stroke/TIA	
□ Depression	□ Irritable Bowel syndrome	□ TMJ	
□ Diabetes (choose below) ___ Type I ___ Type II	□ Kidney problems	□ Tuberculosis	
□ Elevated Cholesterol	□ Kidney stones	□ Vertigo	
□ Epilepsy/seizures	□ Low Blood Pressure	□ Vitamin D deficiency	
□ Fibromyalgia	□ Menopausal		

Patient Name_____ Date of Birth_____

REVIEW OF SYSTEMS

CHECK IF YOU HAVE A HISTORY OF:

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

Revised June 5, 2020

Patient Name_____ Date of Birth_____

SOCIAL HISTORY

CURRENT WORK STATUS:

Working:	□ YES □ NO □ RETIRED	Current or Previous Occupation:
Disabled:	□YES □NO	Reason for disability:
Medical Leave	□ YES □NO	Who took you out of work?
		Last Day Worked?

CURRENT MARITAL STATUS:

□ Single □ Married/Partnered □ Divorced □ Widowed

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* □ YES Year **started**:_____ Year **quit**: _____

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

Revised June 5, 2020

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CHRISTOPHER E. DOERR, D.O., P.C.

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 _____

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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**
195 MILES STREET	13231 JONES STREET	1088 BAXTER STREET, SUITE C
ATHENS, GA 30601	LAVONIA, GA 30553	ATHENS,GA 30606
PHONE: 706-546-1333	PHONE: 706-356-1333	PHONE: 706-549-7400
FAX: 706-546-5807	FAX: 706-356-1433	FAX: 706-549-7399

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:_____

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 195 Miles Street. Athens GA 30601.

Patient or legal representative signature_____ Date _____