867 Greenwood Ave NE
Atlanta, GA 30306
404-600-4627

PATIENT INFORMATION

First Name: ___________________________ MI: _____ Last:___________________________________

Phone: _______________________________ Work: ____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other Sex: ☐Male ☐Female

Social Security Number: ___________________________ Date of Birth: __________________________

Address: _________________________________ City: _____________ State: ______ Zip: ___________

Email Address: ____

Would you like appointment reminders? ☐Yes ☐No If yes; ☐Text ☐Email

How did you hear about us? ☐Doctor ☐Friend ☐Website ☐Attorney ☐Other__________________

Employment Status: ☐Full time ☐Part Time ☐Other (please describe): _________________________

Employer: _______________________________________ Job Title: ______________________________

PHYSICIAN INFORMATION

Did your doctor refer you? ☐Yes ☐No

Referring Provider:_____________________________________ Phone:__________________________

Reason for Referral:____

Other physicians you see:_________________________________ Specialty:________________________

EMERGENCY CONTACT INFORMATION

Name:____________________________________ Relationship:__________________________________

Home/Cell Phone:_________________________ Work Phone: _________________________________

INSURANCE INFORMATION

Insurance Company Name:______________________________ DOB of Guarantor:__________________

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other

Secondary Insurance information (if applicable)

Secondary Insurance Name:______________________________ Phone Number: ____________________

PATIENT HISTORY

Reason for Today's Visit: ____

When did the problem begin?_______________________ Date of Surgery (if applicable): _____________

Have you been treated for this condition before? ☐Yes ☐No

If yes, when and by whom? ____

Is today's visit related to an accident? ☐Yes ☐No Date of Accident:_________________

Where did it happen? ☐Car ☐Work ☐Other: _____________________________

MEDICAL HISTORY

Check all that apply:

☐Allergies	☐Anxiety	☐Osteoarthritis
☐Smoker	☐Asthma	☐Seizures
☐Heart Disease	☐High/Low Blood Pressure	☐Pacemaker
☐Heart Attack	☐Fibromyalgia	☐Headaches
☐Metal Implants	☐Osteoporosis/Osteopenia	☐Stroke
☐Autoimmune Disorder	☐Cancer	☐Diabetes
☐Circulatory Problems	☐Kidney Problems	☐Latex Allergy
☐Multiple Sclerosis	☐Parkinson's Disease	☐HIV

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Have you had any of the following:

☐ XRay ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Nerve Conduction ☐ Other

Please list prior surgeries with approximate dates: ____

____

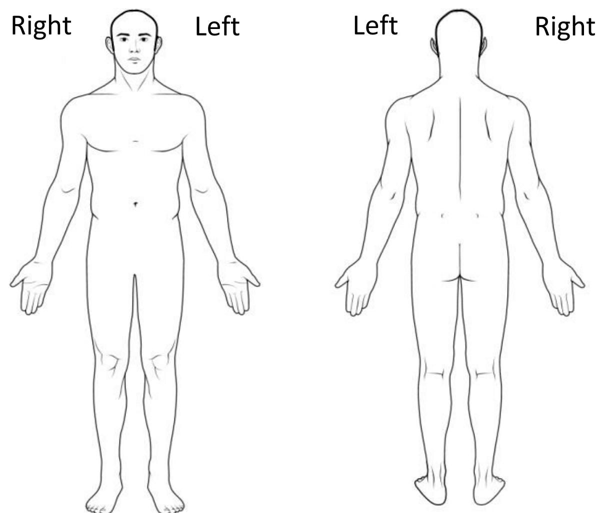
Are you or could you be pregnant? ☐ Yes ☐ No

Have you had two or more falls in the past year? ☐ Yes ☐ No

Have you been injured from a fall? ☐ Yes ☐ No

In the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

Please indicate on the diagram below where you are currently having pain:



Pain Scale										
No Pain									Emergency Room	
0	1	2	3	4	5	6	7	8	9	10

What is your pain level at it's worst?_____________
What is your pain level at it's best?______________
What is your pain level today? __________________

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INSURANCE AND BENEFITS

I the undersigned certify that I (or my dependent), have insurance coverage with the above listed insurance company and assign directly to OnePoint Physical Therapy, Inc. all insurance benefits. I understand that I am financially responsible for all charges that are not payable by insurance. There will be a $30.00 returned check fee. **I understand that it is my responsibility to check with my insurance to see what my benefits will be and if my plan pays in or out of network. I realize that you have verified this, however, that is not a guarantee of benefits or payments**. I also authorize the release of my medical and billing information to my insurance company and Physician if requested to process this claim.

24-HOUR LATE CANCEL/NO SHOW POLICY

We have a 24-hour late cancellation/no show policy. If you fail to show up for your scheduled appointment you will be charged a $30.00 fee. Please call us 24 hours in advance to cancel/reschedule your appointment. Failure to do so will result in a $30.00 charge. This charge will be an out of pocket expense and cannot be billed to your insurance company.

INFORMED CONSENT TO TREAT

I consent to rehabilitation treatment by OnePoint Physical Therapy. Further, I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy. I have the right to ask questions about any potential risks with treatment and questions about my condition throughout the rehabilitation process. I accept the role of participant in my recovery and I am aware that my physician will be kept informed as to the status of my recovery as well as my compliance with therapy and attendance. I understand that it is my responsibility to inform the physical therapist/staff about any changes in health status, medications, or allergies that may affect treatment.

Signature: ____ Date:____________________

Printed Name: ____

Front Office Coordinator:____Date: ____________________