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

GENERAL HISTORY INFORMATION

Child's Name:____ DOB:_______________________ Sex: ☐M ☐F

Parent(s) Name: ______________________________________ Parent SSN: ____________________________

Phone: ____ Work phone:___________________________

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______________________

PEDIATRICIAN INFORMATION

Child's Pediatrician:____ Phone:________________________

Did your Pediatrician refer you? ☐Yes ☐No

If no, name of referring provider:________________________________ Phone:________________________

Reason for Referral:__________________________ Child's age when problems first noticed:____________

Other physicians your child sees:________________________________ Specialty:______________________

EMERGENCY CONTACT INFORMATION

Name:______________________________________ Relationship:___________________________________

Home/Cell Phone:____________________________ Work Phone: ___________________________________

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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): ____

Has your child been treated for this problem before? ☐ Yes ☐ No

If yes, when and by whom? ____

Has your child received any diagnostic imaging related to the problem? ____________________________

Has your child received occupational, physical, or speech therapy in the past or is he/she currently receiving any of these services: ____

Does your child have any difficulty with coordination (Running, jumping, climbing, hopping etc?)_______

____

Does your child have a current IEP (individualized education program): ☐ Yes ☐ No

School History of Child (if applicable) (Name of school/daycare, grade, etc.)_________________________

____

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MEDICAL HISTORY

Did your child have any difficulties during/after birth? ____

Please list any prior surgeries with approximate dates:____

Does your child take any medications? Please list: ____

Does your child have any allergies? Please list:____

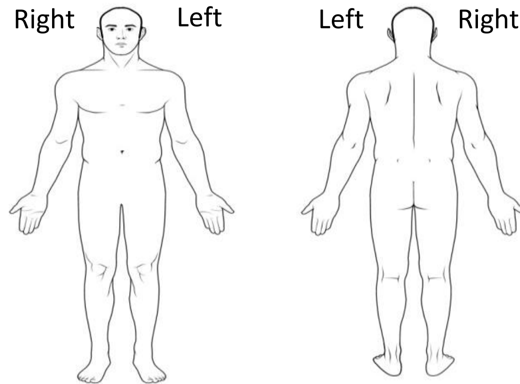
Please describe illnesses, medical issues, or hospitalizations that your child has had and when they occurred: ____

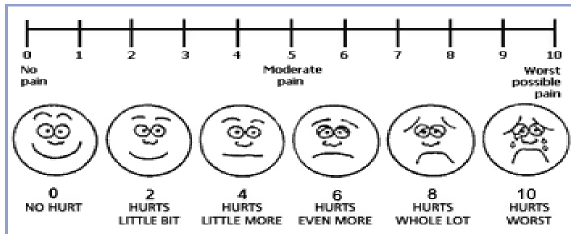
____

Please list current concerns/expectations/goals for your child at this time: _______________________

____

Please indicate on diagram below where you are currently experiencing pain.





Please rate your level of pain from 0-10

Current pain level: ________________

Pain at worst: _____________________

Pain at best: ______________________

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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 MINORS

I consent to rehabilitation treatment for my child by OnePoint Physical Therapy. Further, I acknowledge that no guarantees have been made to me regarding treatment and the treatment results for my child from the rehabilitation therapy.

I have the right to ask questions about any potential risks with treatment and questions about my child's condition throughout the rehabilitation process. I accept the role of my child's participation in their recovery and I am aware that their physician will be kept informed as to the status of their recovery as well as their compliance with therapy and attendance. I understand that it is my responsibility to inform the physical therapist/staff about any changes in my child's health status, medications, or allergies that may affect treatment.

Parent/Guardian Signature: ____________________________________Date:_____________________

Parent/Guardian Name: ____

Patient Name:____

Front Office Coordinator: ____Date: ____________________