
# Patient Information Form

**Date:** _____

**Patient's (Legal) Last Name:** _____ **(Legal) First Name:** _____ **Middle Initial:** _____

**Date of Birth:** _____ **Age:** _____ □ Male □ Female **Social Security Number:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Cell Number:** _____ **Home Number:** _____

**Email** _____

**Employer:** _____ **Work Number:** _____

**Referring Physician Name:** _____ **Phone:** _____

**Primary Care Physician Name:** _____ **Phone:** _____

**What Insurance are we billing TODAY? (Please fill out INSURACE info as printed on card in order to bill correctly) Including ID # and Group #**

**Primary Insurance Company:** _____ ID #: _____ Group #: _____

**Subscriber Name** _____ **Date of Birth** _____ **Relationship** _____

**Secondary Insurance Company:** _____ **ID #:** _____ **Group #:** _____

**Subscriber Name** _____ **Date of Birth** _____ **Relationship** _____

## Consent To Treat

I consent to any medical treatment and/or testing rendered as a patient under the general or special instructions of Medical Rehabilitation Specialists.

## Co-Pays / Assignment of Insurance Benefit

I authorize direct payment of medical benefits to Medical Rehabilitation Specialists (MRS) for services rendered. I understand that MRS will file a claim with my insurance company on my behalf. I understand that my insurance company may only cover a portion of the total bill and I will be responsible for all co-pays, coinsurance and deductible amounts designated by my insurance. I further understand that I may be responsible for all charges not covered by this assignment. If my account becomes delinquent I understand that my account will be forwarded to an outside collection agency. I will be responsible for all cost of the collection process to include legal fees.

_____ Date _____

**(Signature of Patient / Parent or Guardian of Minor)**

2017

Medical Rehabilitation Specialists

# NOTICE OF PRIVACY PRACTICES
# PATIENT ACKNOWLEDGEMENT

We are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following:

Patient Printed Name: _____

May we leave a voicemail message for you?

| | | |
|---|---|---|
| Home Phone | □ Yes | □ No |
| Cell Phone | □ Yes | □ No |
| Work Phone | □ Yes | □ No |

May we speak to someone else regarding your medical care? □ Yes □ No

| Name of Person | Relationship | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

I am aware of the privacy policies of Medical Rehabilitation Specialists. **If you would like a copy of the HIPAA Notice of Privacy Practices to review, one is available upon your request.**

_____ _____

(Signature of Patient) Date Signed

# General Patient Medical History

Medical Rehabilitation Specialists

Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Occupation: _____ Age: _____ Handed: ☐ Right ☐ Left ☐ Ambidextrous

**Have you ever had any of the following diseases or problems?**

- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
  - ☐ Breast
  - ☐ Colon
  - ☐ Lung
  - ☐ Prostate
  - ☐ Skin
  - ☐ Other_____
- ☐ CVA/ Stroke
- ☐ Congestive Heart Failure
- ☐ C O P D
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Pre Diabetes
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ D V T
- ☐ Fibromyalgia
- ☐ Gerd
- ☐ G I Bleed
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Low Back Pain
- ☐ Lupus
- ☐ Neck Pain
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Peripheral Neuropathy
- ☐ Parkinson's Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Thyroid Disorder

**Review of Symptoms Currently Present-Please check all that apply**

- ☐ Fever
- ☐ Chills
- ☐ Malaise
- ☐ Vision loss - one eye
- ☐ Vision loss- both eyes
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Cough with Blood
- ☐ Wheezing
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stools
- ☐ Dysuria
- ☐ Incontinence
- ☐ Urinary Frequency
- ☐ Muscle Cramps
- ☐ Joint Pain
- ☐ Back pain
- ☐ Muscle Weakness
- ☐ Rash
- ☐ Loss of Balance
- ☐ Headaches
- ☐ Numbness
- ☐ Anxiety
- ☐ Depression
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Abnormal Bleeding
- ☐ Hives
- ☐ Runny Nose

**Please check any surgeries you have had**

- ☐ Appendectomy
- ☐ Deep Brain Stimulator
- ☐ Cardiac Bypass
- ☐ Carpal Tunnel Surgery
- ☐ Cervical Diskectomy w/ Fusion
- ☐ Craniotomy
- ☐ Cubital Tunnel Surgery
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Hysterectomy
- ☐ Knee Arthroscopy
- ☐ Lumbar Diskectomy
- ☐ Lumbar Fusion
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ Spinal Cord Stimulator
- ☐ Rotator Cuff Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Tonsillectomy
- ☐ Other _____

**Smoking Status : Never ☐ Current ☐ Former ☐**

**Family History**

- ☐ Unknown
- ☐ No Significant History

| | | |
|---|---|---|
| Cancer _____ | ☐ Mother | ☐ Father |
| Diabetes_____ | ☐ Mother | ☐ Father |
| Heart Disease _____ | ☐ Mother | ☐ Father |
| Hypertension_____ | ☐ Mother | ☐ Father |

Medical Rehabilitation Specialists

# Medications / Allergies

Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Please list current medications.

| | *Medication* | *Dose* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List All Allergies and your Reactions

_____

_____

_____

_____

_____

_____

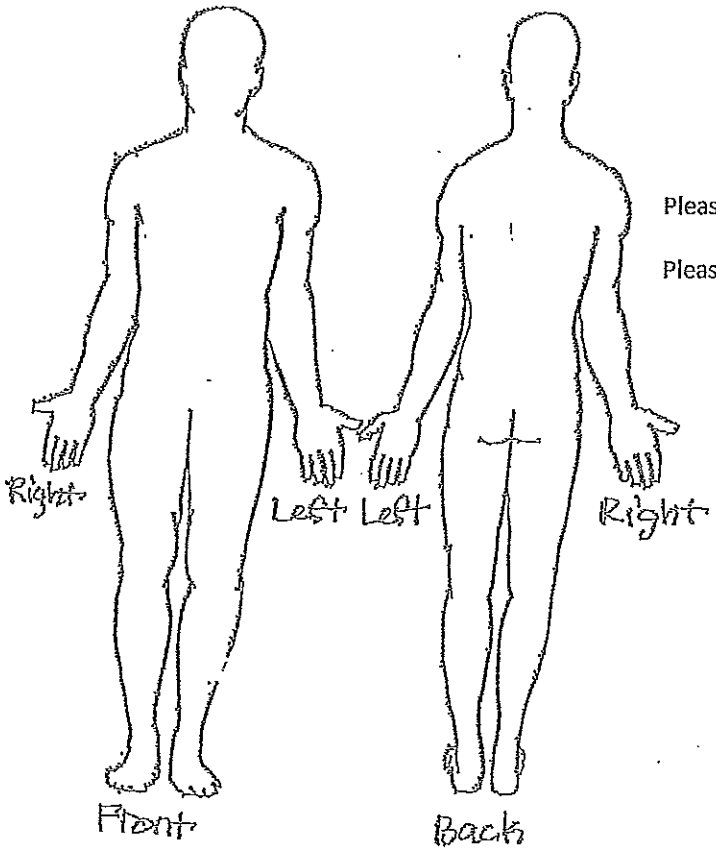
_____

Medical Rehabilitation Specialists

Katharine J. Leppard, M.D.
3470 Centennial Blvd
Suite 110
Colorado Springs, CO 80907
(719) 575-1800)

Name_____

Date_____




Please mark areas of pain with **XXXX**

Please mark areas of tingling and / or numbness with =====

**On a scale in which 0 is no pain and 10 is the worst pain, please rate your pain:**

Best (0-10) _____ Worst (0-10) _____

| **Treatment to Date** | **Yes** | **NO** |
|---|---|---|
| **Physical Therapy** | ___ | ___ |
| **Chiropractic Care** | ___ | ___ |
| **NSAIDS** | ___ | ___ |
| **Testing to Date** | | |
| **X-Ray** | ___ | ___ |
| **MRI** | ___ | ___ |