

Atlantic Physical Therapy Center

ATLANTICPTCENTER.COM

ATLANTICHAND.COM

ATLANTICPELVICHEALTH.COM

Referral Information

Past Patient: ☐ YES ☐ NO

Whom may we thank for referring you to us?

Patient Information

EMAIL:

(Providing email is consenting to receiving emails from Atlantic Physical Therapy Center)

Patient Name: (First, MI, Last, - Sr., Jr., etc)

Social Security #:

Address:

City

State:

Zip Code:

Please check one box as
PRIMARY contact number.

☐ Home Phone: () - -

☐ Cell Phone: () - -

(Providing cell phone is consenting to receive texts. Text and data rates may apply.)

Date of Birth
(mm-dd-yyyy)

Sex:
☐ M
☐ F

Status: ☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Unknown

Date of Injury / Onset Date

Auto Related:

☐ Yes - State? _____

☐ No

Work Related:

☐ Yes

☐ No

Adjustor Name & Telephone #:

Claim # _____

If Workers Comp, was accident with present Employer? ☐ Yes ☐ No

If No, who was employer? _____

Occupation: _____

If Auto Accident, Date of Accident: ____ / ____ / ____

Type of Accident: Driver / Passenger /
Pedestrian / Job / Fall / Other

Do you have Medicare Insurance Coverage? ☐ No ☐ Yes Are you receiving Home Health Services? ☐ No ☐ Yes

Primary Insurance Information (Please DO NOT skip this section)

Name of Insurance Company:

Policy or Claim #:

Group # / Policy Holders Employer:

Policy Holder Name:

Date of Birth:

Policy Holders Phone #:

Policy Holder Address:

Patient Relationship to Policy Holder:

☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto is Primary)

Name of Insurance Company:

Policy or Claim #:

Group # / Policy Holders Employer:

Policy Holder Name:

Date of Birth:

Policy Holders Phone #:

Policy Holder Address:

Patient Relationship to Policy Holder:

☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information

Employer Name:

Employer Phone #:

Employment Status: ☐ None

☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student

Address:

City

State:

Zip Code:

Emergency Contact Information

Contact Name:

Phone #

Relationship to Patient:

☐ Parent ☐ Spouse ☐ Sibling ☐ Child ☐ Other

Financial Policy

As the patient, you are responsible for knowing the policies and procedures of your insurance plan, including pre-certification requirements, limitations, maximum benefits, co-payments, etc. As a courtesy, we will submit all primary and secondary insurance billing. Any remaining balance such as co-insurance, deductible, etc. is your responsibility. If you have any questions, please speak to a member of our office staff.

I _____ authorize Atlantic Physical Therapy Center to treat me as per my doctor's prescription and to release to my insurance company/Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Signature: _____ Date: _____

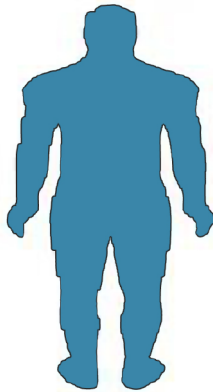
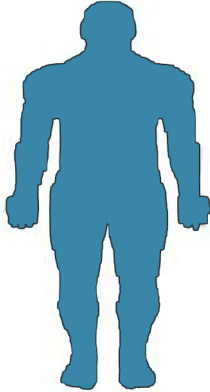
Atlantic Physical Therapy Center Pain Profile

1. What activities increase your problem: _____
2. What activities decrease your problem: _____
3. Are you presently working? Yes ☐ No ☐ Occupation: _____
4. What do you hope to accomplish with PT? _____
5. **REQUIRED BY INSURANCE** – Please provide us your Height: _____ Weight: _____

Please shade/circle in the areas that correspond to your pain or numbness

FRONT

BACK



Please Rate Pain

(0 = none; 10 = worst)

0
1
2
3
4
5
6
7
8
9
10

Injury Information

Work Related Injury Athletic Injury Motor Vehicle Accident Other: _____
Date of Injury / Surgery _____ Date of next doctor's visit _____

Have you ever had these symptoms before? _____

Please check any of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Aspirin |
| <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> Allergies to Heat |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies to Cold |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness / Fainting |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Recent Fractures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Bowel / Bladder Abnormalities | <input type="checkbox"/> Skin Abnormalities |
| <input type="checkbox"/> Liver / Gall Bladder Abnormalities | <input type="checkbox"/> Ringing in your Ears |
| <input type="checkbox"/> Asthma / Breathing Difficulties | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Special Diet Guidelines |
| <input type="checkbox"/> Osteopenia / Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis |

Is there any information in your past medical history that we should know about?

Are you presently taking any medication? _____ if yes, please list medications:

Patient Name (Printed): _____

Patient Signature _____ Date _____

HIPAA PRIVACY POLICY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Disclose health information in order to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.

Disclose your health information in order to receive payment for the services we provide to you.

Disclose your health information for normal healthcare operations such as quality assessments and physician certifications.

PATIENT RIGHTS REGARDING MEDICAL INFORMATION

The Right to Inspect and Copy Your Information: You may review and copy your medical records and information.

The Right to Amend: You may ask that we amend your health information if you believe that your information is incomplete or incorrect.

The Right to Request Restrictions: You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers.

The Right to Confidential Communications: You may request that we communicate with you about medical matters in a certain format or a specific location.

The Right to Receive a Copy of this Notice: You may request and receive a copy of this notice (or our current notice) at any time by contacting this organization.

Print Patient Name

Relationship to Patient

Signature

Date

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer every question, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD9 Code: