PINNACLE REHABILITATION

SUMMIT SURGICAL

Patient Name **DOB**

Patient Name: _____ _____ _____ SS#: _____
(First) (MI) (Last)

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Home Address: _____ P.O. Box: _____

City.: _____ State: _____ Zip Code: _____

Home Phone:( ) _____ Cell Phone:( ) _____ E-mail address: _____

Employer: _____ Work Phone: ( ) _____ Spouse Name: _____

Spouse Employer: _____ Work Phone: ( ) _____ Spouse DOB: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Physician: _____ Primary Physician: _____

Pharmacy & Location: _____ Phone: ( ) _____

I give permission for Summit Surgical, DBA Pinnacle Rehabilitation to contact the patient's pharmacy for a list of medications. ❑Yes ❑No

Race: ❑Hispanic ❑Asian ❑Caucasian ❑Black/African American ❑American Indian or Alaska Native ❑Other: _____

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

Ethnicity (Nationality-cultural background): ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Other

-Person Responsible for Payment of Account-

Name: _____ Relationship: _____

Address: _____ Home Phone: ( ) _____

City, St., Zip: _____ Other Phone: ( ) _____

-Insurance Information-

Please Present Card(s) for Copying

Primary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip _____

Other Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip _____

-Complete if Student or Under the age of 18-

Father Information

Name: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

SS#: _____ DOB: _____

Mother Information

Name: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

SS#: _____ DOB: _____

I hereby give my consent to Summit Surgical, DBA Pinnacle Rehabilitation and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Summit Surgical, DBA Pinnacle Rehabilitation chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative: _____ **Date:** _____

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-Acknowledgement of Receipt of Privacy Notice-

I acknowledge I have received a copy of Summit Surgical, DBA Pinnacle Rehabilitation's Notice of Privacy Practices effective April 2003.

-Authorization for Medical Care-

I hereby authorize Summit Surgical, DBA Pinnacle Rehabilitation to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-Referral Waiver-

I acknowledge in the course of my treatment, Summit Surgical, DBA Pinnacle Rehabilitation, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Summit Surgical, DBA Pinnacle Rehabilitation will notify me when such a referral occurs Summit Surgical, DBA Pinnacle Rehabilitation assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Summit Surgical, DBA Pinnacle Rehabilitation make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. Summit Surgical, DBA Pinnacle Rehabilitation is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below, ***I give permission to the person(s) listed to receive LIMITED information about my care.*** I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. **Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization.** This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1. ☐ Do **NOT** share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name: _____ **Name:** _____

College or High School Athletic Department: _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

_____ _____ _____

Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: _____

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PROBLEM or ACCIDENT/INJURY INFORMATION

Briefly explain why you are here today: _____

- What body part? _____ ❑**Right** ❑**Left** ❑**Bilateral**
- Have you had x-rays of this area? ❑**Yes** ❑**No** If yes, what facility? _____

  If yes, do you have the X-rays with you? ❑**Yes** ❑**No**

Have you had an MRI of this area? ❑**Yes** ❑**No** If yes, what facility? _____

If yes, do you have the MRI with you? ❑**Yes** ❑**No**

Is this an injury? ❑Yes ❑No

If yes Injury Date: _____ How did injury occur: _____

Where did the injury occur? _____

Type: ❑Motor Vehicle ❑Sports Injury ❑Worker's Compensation ❑Liability ❑Other: _____

Is there legal action pending related to your problem? ❑Yes ❑No

If yes, attorney's name_____

Have you been treated by another healthcare provider for this problem? ❑**Yes** ❑**No**

If yes, name of provider(s)_____

How long were you treated? _____

Please check the boxes of the following tests/treatments you have received for this problem and tell us where you had the test/treatment.

❑CT Scan - Where was the test performed? _____

❑Bone Scan - Where was the test performed? _____

❑Nerve Conduction Test - Where was the test performed? _____

❑Lab test(s) - Where was the test(s) performed? _____

❑Chiropractic

- Name of provider: _____
- When did you receive treatment? _____

❑Physical Therapy

- Name of provider: _____
- When did you receive treatment? _____

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DESCRIPTION OF PAIN and SYMPTOMS:

Was the onset of your pain: ❑ Sudden ❑ Gradual

How long have you had this pain: _____ ❑ days ❑ weeks ❑ months ❑ years

On a scale from 0-10, rate your pain, 0-None - 10-unbearable: _____

Have you had this pain before? ❑ Yes ❑ No **If yes, how long ago?** _____

How often do you have pain? ❑ Intermittent ❑Occasional ❑Constant ❑Rare

Is your pain: ❑Changing ❑Stable ❑Worsening ❑Improving ❑Resolved

Does your pain radiate: ❑Yes ❑No Radiates to:_____

How does your pain feel? ❑Aching ❑Burning ❑Dull ❑Piercing ❑Sharp ❑Throbbing ❑Other_____

What aggravates your symptoms/pain?

❑Bending	❑Lifting	❑Sitting	❑Other:_____
❑Climbing Stairs	❑Movement	❑Standing	**❑Nothing**
❑Descending Stairs	❑Pushing	❑Walking	

What reduces your symptoms/pain?

❑Brace/Splint	❑Ice	❑Mobility	❑Rest
❑Elevation	❑Injection	❑Ibuprofen	❑Stretching
❑Exercise	❑Massage	❑Tylenol	❑Other:_____
❑Heat	❑Prescription Meds	❑Physical Therapy	**❑Nothing**

Associated Symptoms: Please mark the symptoms you currently are experiencing:

❑Bruising	❑Limping	❑Spasms
❑Grinding	❑Locking	❑Swelling
❑Decreased mobility	❑Nighttime awakening	❑Tingling in the arms
❑Difficulty initiating sleep	❑Nighttime pain	❑Tingling in the legs
❑Joint instability	❑Numbness	❑Weakness
❑Joint tenderness	❑Popping	**❑No concerns with any of these**

Other associated symptoms: _____

MEDICAL HISTORY

Please select any problems you <u>currently have or have had</u> in the past.

❑NONE OF THESE APPLY TO ME

❑Aids/HIV	❑Congestive heart failure	❑Gout	❑Heart Attack **year:**_____
❑Alcoholism	❑COPD	❑Hepatitis **type:**_____	❑Rheumatoid arthritis
❑Anemia	❑Coronary artery disease	❑High Cholesterol	❑Seizure disorders
❑Arthritis	❑Depression	❑Hypertension	❑Sleep apnea
❑Asthma	❑Diabetes	❑Inflammatory Bowel Disease	❑Lupus
❑Atrial fibrillation	❑Drug Abuse	❑Kidney disease	❑Stomach ulcer
❑Cancer	❑Blood Clot	❑Liver disease	❑Thyroid problems
type:_____	❑Fibromyalgia	❑Osteoporosis	❑Other:_____
❑ Stroke	❑GERD		

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SURGICAL HISTORY

Please list all previous surgeries and the approximate year:

❑I HAVE NOT HAD ANY SURGERIES

Surgery:	Year:

Surgery:	Year:
❑ Pacemaker	
❑ Heart Stents	
❑ Bypass Surgery	
❑ Replacement Valves	
❑ Defibrillator	

SOCIAL HISTORY

Hand Dominance: ❑Right ❑Left ❑Ambidextrous

How often do you exercise? ❑Never ❑Occasionally ❑Daily

Type: _____

Do you live alone? ❑Yes ❑No

MEDICATIONS & ALLERGIES

Please list all medications which you are currently taking: (include vitamins, supplements, herbs, **over the counter**, etc.)

❑Currently taking <u>NO</u> medications (including over the counter)

Medication	Dose

Do you have any allergies? ❑ Yes ❑ No If yes, please list below with the **reaction** to the allergy:

_____

_____

_____

_____

_____