

ARS Hand and Physical Therapy
505 Morris Avenue, Suite 103
Springfield, NJ 07081

PLEASE COMPLETE ALL INFORMATION

HOW DID YOU HEAR ABOUT US? PHYSICIAN FRIEND AD ONLINE OTHER _____

PHYSICIAN/FRIEND (NAME): _____

EMAIL ADDRESS: _____

LAST NAME _____ MIDDLE _____ FIRST _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH _____ AGE _____ SEX _____

MARITAL STATUS: MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____

SPOUSE'S NAME _____

EMPLOYER _____

OCCUPATION _____ FULL TIME _____ PART-TIME _____ RETIRED _____

INSURANCE INFORMATION

MOTOR VEHICLE ACCIDENT INFORMATION

INSURED'S NAME _____

INSURED'S ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF MOTOR VEHICLE ACCIDENT ____/____/____ PLACE OF ACCIDENT _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

ADJUSTER'S NAME _____ ADJUSTER'S PHONE NUMBER _____

POLICY # _____ CLAIM # _____

HEALTH INSURANCE SECONDARY TO MOTOR VEHICLE

PRIMARY INSURANCE: _____

ID NUMBER _____ GROUP NO _____

ADRESS OF INSURANCE COMPANY _____

INSURANCE TELEPHONE _____

SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT: _____

RELATIONSHIP TO PATIENT: SELF _____ SPOUSE _____ PARENT _____ OTHER _____

INSURED'S DATE OF BIRTH IF NOT PATIENT _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

SIGN _____ DATE _____

I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO ADVANCED REHAB SOLUTIONS FOR SERVICES RENDERED.

SIGN _____ DATE _____

I HAVE RECEIVED MY NOTICE OF PRIVACY POLICIES FROM ADVANDED REHAB SOLUTIONS

SIGN _____ DATE _____

**ADVANCED REHAB SOLUTIONS, LLC
505 MORRIS AVENUE
SPRINGFIELD, NJ 07081**

Our office will submit your claims to your carrier for payment. Please do not submit this claim yourself. If there is any deductible or co-insurance due to this office that has not been paid, a statement will be forwarded to you reflecting this amount. You will also receive an Explanation of Benefits from your carrier describing your claim. If there are monies due from you, this office will bill you accordingly. Should the reimbursement check come directly to you, please forward it to this office within ten (10) days.

There will be a \$30.00 returned check fee for any checks that are returned to this office. Should your account be placed in collection, a collection agency fee up to fifty percent (50%) will be added to the amount due and all three credit reporting agencies will be notified.

By signing this statement, you agree to reimburse Advanced Rehab Solutions, LLC, for any monies you received from your insurance carrier.

RESPONSIBLE PARTY SIGNATURE

DATE

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below with whom our office can or cannot leave a message. Please check where appropriate.

	<u>YES</u>	<u>NO</u>	<u>DOES NOT APPLY</u>
Spouse	_____	_____	_____
Parent	_____	_____	_____
Children	_____	_____	_____
Answering Machine	_____	_____	_____
Home	_____	_____	_____
Work	_____	_____	_____

Are we you able to receive telephone calls at your work place? Yes _____ No _____

May we call you at your work place and state who is calling? Yes _____ No _____

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	<u>YES</u>	<u>NO</u>	<u>DOES NOT APPLY</u>
Spouse	_____	_____	_____
Children	_____	_____	_____
Parent	_____	_____	_____

Parent, Children, Spouse and/or Significant Others:

Name _____
 Relationship _____
 Phone _____

Name _____
 Relationship _____
 Phone _____

Patient Name _____ Age _____ Today's Date _____

Occupation: _____ Are you on a work restriction from your doctor? Yes No

If yes, what restrictions _____

Activities that comprise your workday (I.E. Computer/Lifting) _____

Leisure activities/exercise routines: _____

Do you smoke? Yes No If yes how much? _____ Packs/Day

Drink alcohol? YES NO If yes how much? _____ Drinks/week

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

ALLERGIES: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems/asthma | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., drugs/alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

List any other medical problems _____

Do you have any significant immediate family history of illness or disease? YES NO If yes please list

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Please list any medications you are currently taking or provide us a list and we will attach to your chart:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO If yes how long _____

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries including dates:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

What are your current symptoms? _____

What do you think caused your symptoms? _____

Approximately when did they start? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

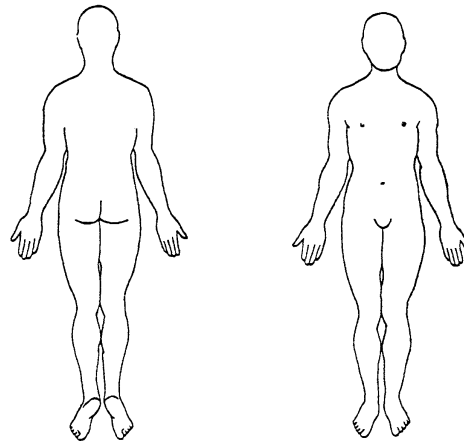
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: YES NO If yes, when _____

Treatment received _____ Was there improvement? YES NO

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



- X** Shooting/sharp pain
- O** Dull/aching pain
- /** Numbness or Tingling

My symptoms currently: Come and go Are Constant Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please circle:

Your current level of pain while completing this survey: 0 1 2 3 4 5 6 7 8 9 10 out of 10

The best your pain has been during the past 48 hours: 0 1 2 3 4 5 6 7 8 9 10 out of 10

The worst your pain has been during the past 48 hours: 0 1 2 3 4 5 6 7 8 9 10 out of 10

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

Signature of Patient _____ Reviewed by Therapist _____ Date _____