CHPT
Complete Hometown Physical Therapy

201A North Main St | Hallettsville, TX 77964 | (361) 798-3500
105 Boehm Dr | Shiner, TX 77984 | (361) 594-8301
211 W May St | Yoakum, TX 77995 | (361) 407-5091
www.completehometownpt.com

Patient Demographic Sheet

Referred by: _____

Last Name: _____ **First Name:** _____

Mailing Address: _____ **Apt/Ste:** _____

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

Gender: _____ **Marital Status:** _____ **E-mail:** _____

Employer: _____ **Occupation:** _____

Phone (Home):_____ **(Work)** _____ **(Cell)** _____

Date of Birth: _____ **SSN:** _____ **Driver's License #:**_____

Emergency Contact: 1) Name _____ **Phone** _____ **Relationship** _____

2) Name _____ **Phone** _____ **Relationship** _____

Primary Insurance: Insurance Co: _____ **Policy ID #:** _____

Group#: _____ **Policy Holder Name:** _____

Date of Birth: _____ **SSN:** _____ **Employer:** _____

Address (if different from Pt): _____

City _____ **State:** _____ **Zip:** _____**Relationship to Pt:** _____

Secondary Insurance: Are you covered by a secondary insurance? ☐ YES / ☐ NO

Insurance Co: _____ **Policy ID #:** _____

Group#: _____ **Policy Holder Name:** _____

Date of Birth: _____ **SSN:** _____ **Employer:** _____

Address (if different from Pt): _____

City _____ **State:** _____ **Zip:** _____**Relationship to Pt:** _____

Please read and sign the back of this form. Thank You!

- Please try to provide at least 24 hours notice if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday.

- I hereby give authorization for payment of medical and/or auto insurance benefits and/or legal settlement payments to be made directly to Complete Hometown Physical Therapy, and for any assisting therapist employed by or contracted with Complete Hometown Physical Therapy.
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- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance, provided I am notified in advance that any proposed service or therapy/treatment/procedure may not be covered by patient's insurance provider(s).

- I understand that all copay, coinsurance and deductible amounts are due and payable at the time of service, unless a payment arrangement has been made with the billing. If the explanation of benefits from the insurer(s) shows a remaining patient balance due, the patient will be billed accordingly.

- In the event of a default in payment, the prevailing party in any lawsuit or mediation will be entitled to recover reasonable attorney fees and actual costs of collection.

- I hereby authorize Complete Hometown Physical Therapy. to release any and all information necessary to secure payment of benefits to only those parties legally entitled to receive information for purposes of receiving payment of existing balances or for authorization for continuation of services as may be necessary or requested by the patient's insurer(s).

- I agree that a photocopy of this agreement shall be as valid as the original.

Thank you for you cooperation.

Patient (if minor – Parent or Legal Guardian) Signature: _____

Date: _____

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Patient Medical History

Name: _____ Referring Physician: _____

Primary Physician: _____

Are you currently taking any prescription or non-prescription medications? ☐ Yes / ☐ No

Please list all medications: _____
_____

Have you had any of the following Medical or Rehabilitative Service for this Injury/Episode? (check one)

Chiropractor	☐ Yes	☐ No	CT Scan	☐ Yes	☐ No
EMG/NCV	☐ Yes	☐ No	General Practitioner	☐ Yes	☐ No
Massage Therapy	☐ Yes	☐ No	MRI	☐ Yes	☐ No
Myelogram	☐ Yes	☐ No	Neurologist	☐ Yes	☐ No
Occupational Therapist	☐ Yes	☐ No	Orthopedist	☐ Yes	☐ No
Physical Therapist	☐ Yes	☐ No	Podiatrist	☐ Yes	☐ No
Emergency Room	☐ Yes	☐ No	X-Rays	☐ Yes	☐ No

Other: _____

General Health Information: Do you know or have you had ANY of the following? Check all that apply.

Asthma, Bronchitis, or Emphysema	☐ Yes	☐ No	Severe or Frequent Headaches	☐ Yes	☐ No
Shortness of Breath/Chest Pain	☐ Yes	☐ No	Vision or Hearing Difficulties	☐ Yes	☐ No
Coronary Heart Disease or Angina	☐ Yes	☐ No	Numbness or Tingling	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Dizziness or Fainting	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Heart Attack or Surgery	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Weight Loss/Energy Loss	☐ Yes	☐ No
Blood Clot/Emboli	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Thyroid Trouble/Goiter	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Any Pins or Metal Implants	☐ Yes	☐ No
Infectious Disease	☐ Yes	☐ No	Joint Replacement	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Neck Injury/Surgery	☐ Yes	☐ No
Cancer or Chemotherapy/Radiation	☐ Yes	☐ No	Shoulder Injury/Surgery	☐ Yes	☐ No
Arthritis/Swollen Joints	☐ Yes	☐ No	Elbow/Hand Injury/Surgery	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Back Injury/Surgery	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Knee Injury/Surgery	☐ Yes	☐ No
Sleeping Problems/Difficulties	☐ Yes	☐ No	Leg/Ankle/Foot Injury/Surgery	☐ Yes	☐ No
Emotional/Psychological Problems	☐ Yes	☐ No	Are You Pregnant?	☐ Yes	☐ No
Bowel or Bladder Problems	☐ Yes	☐ No	Do You Smoke?	☐ Yes	☐ No

List any other information that would assist us in your care: _____
_____

Are you aware of your diagnosis? ☐ Yes / ☐ No
Based upon your awareness, what are your expectations/goals in this program? _____
_____

Patient/Guardian Signature: _____ Date: _____