



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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CT Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EMG/NCV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	General Practitioner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Massage Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Myelogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occupational Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthopedist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Podiatrist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Room	<input type="checkbox"/> Yes	<input type="checkbox"/> No	X-Rays	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other: _____

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

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