New Patient Form

OFFICE USE ONLY

Date	H	W	BP	Pulse

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth	SSN

Address	City	State	Zip

Please check preferred phone number	Cell Phone ☐	Home Phone ☐	Work Phone ☐

Email Address	Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐ Widowed ☐Other

Assigned Sex at Birth F M	Primary Language Spoken	Race (Optional)	Ethnicity (Optional)

Primary Care Physician	City	Phone

Referring Physician	City	Phone

Pharmacy	Address	Zip	Phone

EMERGENCY CONTACT

Last Name	First Name	Phone	Relationship to Contact

PRIMARY INSURANCE

Insurance Company	Copay (specialist) $
Subscriber ID/Policy Number	Group Number
Subscriber (if policy is held by spouse/parent):	DOB

SECONDARY INSURANCE

Insurance Company	Copay (specialist) $
Subscriber ID/Policy Number	Group Number
Subscriber (if policy is held by spouse/parent):	DOB

LABOR & INDUSTRY/MOTOR VEHICLE ACCIDENT ONLY

Note: we do not bill 3rd party auto claims

Is your claim active? No Yes	Claim Number	Policy Number	Date of Injury/accident

Insurance Carrier Name	Address	Name of Attorney

Claim's Manager Name	Phone Number	Fax Number

REASON FOR VISIT

Last Name	First Name	DOB	Age	Height	Weight	Dominant Hand

Please briefly describe the reason for today's visit

____

Onset date of symptoms:	Describe your symptoms (check all that apply)		Your symptoms are	Today, your level of discomfort/pain is	Did you stop working due to your pain?
________	Aching	Stabbing	Occasional	No Pain	No Yes
Duration of symptoms:	Burning	Superficial	Frequent	Mild	Is one of your goals to return to work?
________	Deep	Throbbing	Constant	Moderate	No Yes
(days, weeks, months)	Dull	Other________	Worsening	Severe	Is the pain tolerable?
	Sharp	________	Improving		No Yes Sometimes

REASON FOR VISIT (CONTINUED)

Mark the areas on your body where you typically feel symptoms. Include all affected areas

Associated Symptoms

- Balance Issues
- Bruising
- Buckling
- Catching/Locking
- Chills
- Drainage
- Fever
- Grinding
- Instability
- Loss In Bowel/Bladder
- Numbness
- Popping/Clicking
- Radiation Down Arm/Leg
- Redness
- Swelling
- Tingling
- Warmth
- Weakness
- Weight Loss

Indicate your current level of discomfort/pain below

0 No pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst pain ever

What makes your symptoms **BETTER**?

What makes your symptoms **WORSE**?

MEDICATION AND FOOD ALLERGIES

☐ No Known Allergies

List all known allergies (drugs, food, animals, etc.)

- IV contrast dye
- Latex
- Local anesthetics
- Shellfish

CURRENT MEDICATIONS

☐ I do not take any medications

List all current medications including OTC's, Supplements, Vitamins, and Herbals

Name of medication	Dosage/Frequency	Prescribing Physician

SURGICAL HISTORY

☐ I have not had any surgical procedures

Please list any surgical procedures you have had

Surgery	Date (month/year)	Surgeon

FAMILY HISTORY

☐ Adopted

Please list all medical problems of your **immediate** family (such as diabetes, high blood pressure, heart disease, etc.) If deceased, please indicate cause of death.

SOCIAL HISTORY

☐ Disability

Occupation	Current Employer

Highest Level of Education	Marital Status	Do you have children? No Yes	How many?

Nicotine Use Never	Frequency/Quantity	Type
Alcohol Use Never	Frequency/Quantity	Type
Recreational Drug Use Never	Frequency/Quantity	Type

Cannabis Use Never	Frequency/Quantity	How does cannabis help you?
Have you had any negative effects from cannabis? No Yes	If yes, please describe:	

What are you doing for exercise?	HOME SETUP	Number of Step to Enter	Number of Levels	1st Floor Bed & Bath No Yes

REVIEW OF SYSTEMS

☐ None of the below

Please check any conditions that apply to you, currently or past.

Anemia	Fractures	Insomnia	Pulmonary Embolism
Anxiety	GERD/Reflux	Joint Infection	Rheumatoid Arthritis
Arthritis	Glaucoma	Kidney Disease/Stones	Seizures/Epilepsy
Asthma	Gout	Leg or Foot Ulcers	Sexually Transmitted Infection
Bleeding/Clotting Disorder	Headaches/ Migraines	Lipid/Cholesterol	Stroke
Cancer	Heart Attacks	Liver Disease	Substance Abuse
COPD/Emphysema	Heart Murmur	Lung Disease	Tendonitis
Coronary Atherosclerosis	Hepatitis	Meningitis	Thyroid Problems/Disease
Depression	Hernia	Mononucleosis	Tuberculosis
Diabetes	Herniated Disc	Osteoporosis	Ulcers
Diverticulitis	HIV/AIDs	Pacemaker	Urinary Tract Infection
Fibromyalgia	Hypertension	Peripheral Vascular Disease	Vision Loss

Other conditions not listed above:

ADDITIONAL INFORMATION

Is there anything else you would like us to know?

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By signing below I agree to the following:

The information supplied on this form is accurate and up-to-date to the best of my knowledge. I have reviewed a copy of the Rehabilitation Physicians of Pittsburgh financial policy and I agree to the terms and conditions. I allow the Rehabilitation Physicians of Pittsburgh to participate in the treatment of my health. I authorize the Rehabilitation Physicians of Pittsburgh to release information to my insurance company, my referring/consulting physicians or other healthcare providers as deemed appropriate

I hereby authorize my insurance benefits to be paid directly to the Rehabilitation Physicians of Pittsburgh and acknowledge the release of this information to my insurance company. I understand I am financially responsible for my co-pay, deductible/coinsurance and for non-covered services. I authorize my doctor to act as my agent in helping me obtain payment from the insurance. I agree that I will not withhold or delay payment if my insurance denies payment on any of my charges. I have been informed of the $35 fee on all return checks. In the event it should become necessary to involve a collections agency for unpaid balances, I agree that I will be responsible for unpaid balances, collection fees and interest. Should legal action be filed, I will accept financial responsibility for reasonable attorney fees, filing fees and any other accrued costs will be my responsibility. I attest that I have read the Notice of Privacy Practices which is posted in the reception area and also on the website (www.REHABPGH.com) and acknowledge that a hard copy of this is available to me at my request.

I am aware of the $25 charge for all late cancellations (less than 24 hours notice) and no show appointments. I am aware of the $50 charge for all no-show new patient and procedure appointments.

I permit a copy of this authorization to be used in place of the original.

____ ____________________

Patient/Responsible Party Signature **Date**