Today's Date:_____

Name: First_____ MI_____ Last_____ Date of Birth:_____

Home Address:_____ Social Security #:_____

City:_____ State:_____ Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ ☐ Male ☐ Female

Emergency Contact:_____ Phone:_____ Relationship:_____

Employer:_____ Address:_____ Phone:_____

If the patient is a minor or dependent, please complete this information:

Father's Name:_____ DOB:_____ SS#:_____

Father's Employer:_____ Work Phone #:_____

Mother's Name:_____ DOB:_____ SS#_____

Mother's Employer:_____ Work Phone #:_____

Have you received any PT, OT, Speech, or Chiropractic services this year? Yes No

How did you hear about Gulf Coast Therapy? ☐ Referring Provider ☐ Current/Former Patient
☐ Website ☐ Internet/Google ☐ Friend/Family/Employee

Responsible Party Information

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify Gulf Coast Therapy, Inc. of any changes in my status or the above information. I hereby authorize treatment(s) agreed upon with the therapist and my referring physician which are deemed medically necessary. Accounts not paid in ful within thirty (30) days following completion of therapy and the billing process, may be turned over to collection.

I have been informed of my HIPAA rights and I authorize the release of any information pertinent to my case to any insurance company, adjuster, referring physician, or attorney involved in this case. I also authorize Gulf Coast Therapy and its staff to call my home and leave messages regarding appointments with my spouse and/or answering machine. Furthermore, I authorize the use of facsimile, email, internet, and electronic transmissions of my personal health information for the purpose of treatment, payment, and healthcare operations.

Responsible Party Signature:_____ Date:_____

NEXT SCHEDULED APPOINTMENT WITH REFERRING PHYSICIAN: Date:_____ Time:_____

Missing 3 appointments without notification may result in you being discharged from therapy and notification to your physician

$25 CHARGE FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION

PATIENT MEDICAL HISTORY

NAME: _____ REFERRING PHYSICIAN: _____

FAMILY PHYSICIAN: _____ IS AN ATTONEY INVOLVED IN THIS CASE? YES NO

HAVE YOU HAD SURGERY FOR THIS INJURY? YES NO NUMBER OF SURGERIES 1 2 3 4

TYPE OF SURGERY: _____

PLEASE ENTER YOUR: HEIGHT_____ WEIGHT _____ AGE_____

DO YOU HAVE A LIVING WILL? YES NO

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
LUNG/BREATHING PROBLEMS	_____	_____	DIABETES	_____	_____
HEART CONDITION	_____	_____	CANCER	_____	_____
DO YOU HAVE A PACEMAKER	_____	_____	ARTHRITIS/SWOLLEN JOINTS	_____	_____
HIGH BLOOD PRESSURE	_____	_____	OSTEOPOROSIS	_____	_____
BLOOD CLOT/EMBOLI	_____	_____	ALLERGY TO LATEX	_____	_____
EPILEPSY/SEIZURES	_____	_____	ANY JOINT/METAL IMPLANTS	_____	_____
INFECTIOUS DISEASE	_____	_____	DIZZINESS	_____	_____

PLEASE LIST ANY HERBAL, VITAMIN, SUPPLEMENTS, OVER THE COUNTER, AND PRESCRIPTION MEDICATIONS YOU MAY BE TAKING:

Name	Doseage	Frequency	O=Oral, I=Injection, T=Transdermal

LIST ANY OTHER INFORMATION THAT WOULD ASSIST US IN YOUR CARE: _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____ DATE:_____