Alyeska Therapy Center, Inc.

Patient Information Form

Patient Information

Last Name ______ First Name ______ MI ____ SSN ______

Address ______

Address2 ______ City ______ State ____ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Date of Birth ______ Gender ____ Marital Status ______ Email ______

Emergency Contact

Last Name ______ Relationship ______

First Name ______ Phone ______

Employer

Name ______ Phone ______

Address ______

City ______ State ____ Zip ______

Problem

Problem Description ______ Date of Injury ______ Last Physician Visit / / ______

Referred By ______ Primary Care Physician ______

Latest Referral Information ______ Motor Vehicle Accident ____

Latest Plan of Care ______ That occurred in: ____

Notes: ______

Primary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ____ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Secondary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ____ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Tertiary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ____ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature:______ Date:______

Birth History: ____
____

Describe the problem for which you seek occupational/physical/speech therapy for your child.
____

What are your personal goals for your child in occupational/physical/speech therapy?
____

Is your child receiving services from anyone else for this problem?
____

What medications is your child taking? (prescription and non-prescription)
____

Has your child had any medical tests?(MRI, X-ray, EMG, Vision, Hearing, Swallow, etc.)
____

Medical History:
Allergies (latex, food, meds, environmental):____
Please check if your child has had any of the following problems:

□ Heart Condition	□ Lung Condition	□ Vision Loss
□ Pacemaker	□ Psychological	□ Artificial Joint
□ Circulatory Problems	□ Head Injury	□ Infectious Disease
□ Diabetes	□ Seizures/Epilepsy	□ Osteoporosis
□ Hypertension	□ Fractures	□ Arthritis
□ Stroke	□ Neck Injury	□ Surgery
□ Cancer	□ Back Injury	□ Other
□ Neurological Disease	□ Hearing Loss	

Brief history of surgeries and categories checked:
____
____
____

Within the past year, has your child had any of the following symptoms? (Check all that apply)

□ Chest pain	□ Falling	□ Difficulty swallowing
□ Heart palpitations	□ Difficulty walking	□ Bowel problems
□ Persistent or productive cough	□ Joint pain or swelling	□ Weight loss or gain
□ Hoarseness	□ Pain at night	□ Urinary problems
□ Shortness of breath	□ Difficulty sleeping	□ Fever/Chills/Sweats
□ Dizziness or blackouts	□ Loss of appetite	□ Headaches
□ Weakness in arms or legs	□ Nausea/Vomiting	□ Loss of balance

□ Other:____________________

Brief history of symptoms checked:
____
____

Please describe any other medical history or information related to condition.

____

____

Daily Routine (wake up time, meal times, school, daycare, bed time):

____

____

____