

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>			<input type="radio"/> Female	<input type="text"/>		
<input type="text"/>			<input type="radio"/> Male	<input type="text"/>		
Patient name Last First MI			Patient date of birth			
Patient address				City	State	Zip code
Patient insurance ID#		Health plan		Group number		
Referring physician (if applicable)		Date referral issued (if applicable)		Referral number (if applicable)		

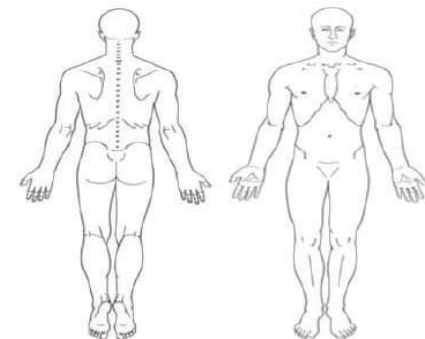
Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)					2. Federal tax ID(TIN) of entity in box #1					
<input type="text"/>					<input type="text"/>					
3. Name and credentials of the individual performing the service(s)					4. Alternate name (if any) of entity in box #1					
<input type="text"/>					<input type="text"/>					
4. Alternate name (if any) of entity in box #1					5. NPI of entity in box #1					
<input type="text"/>					<input type="text"/>					
7. Address of the billing provider or facility indicated in box #1					8. City		9. State		10. Zip code	
<input type="text"/>					<input type="text"/>		<input type="text"/>		<input type="text"/>	

Provider Completes This Section:

Date you want THIS submission to begin: <input type="text"/>	Cause of Current Episode (1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical (5) Work related (6) Motor vehicle	Date of Surgery <input type="text"/>	Type of Surgery (1) ACL Reconstruction (2) Rotator Cuff/Labral Repair (3) Tendon Repair (4) Spinal Fusion (5) Joint Replacement (6) Other	Diagnosis (ICD code) Please ensure all digits are entered accurately 1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Patient Type (1) New to your office (2) Est'd, new injury (3) Est'd, new episode (4) Est'd, continuing care	DC ONLY Anticipated CMT Level (1) 98940 (2) 98942 (3) 98941 (4) 98943	Current Functional Measure Score Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (other) <input type="text"/>		
Nature of Condition (1) Initial onset (within last 3 months) (2) Recurrent (multiple episodes of < 3 months) (3) Chronic (continuous duration > 3 months)				

Patient Completes This Section:

Symptoms began on: <input type="text"/>	Indicate where you have pain or other symptoms: 
1. Briefly describe your symptoms: <input type="text"/>	
2. How did your symptoms start? <input type="text"/>	
3. Average pain intensity: Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain	
4. How often do you experience your symptoms? (1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)	
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) (1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely	
6. How is your condition changing, since care began at this facility? (0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better	
7. In general, would you say your overall health right now is... (1) Excellent (2) Very good (3) Good (4) Fair (5) Poor	

Patient Signature: X Date: _____

#

REGISTRATION FORM

Date: _____

Name _____ SS: _____

Home Phone _____ Mobile (Cell) Phone _____

Address _____ City/State _____ Zip _____

Age _____ Birth Date _____ Marital Status M S W D

Email _____ How Many Children? _____

Occupation _____ Employer _____

Address _____ City/State _____ Zip _____ Phone _____

Name of Spouse _____ Occupation _____

Patient's Nearest Relative _____ Address _____

City/State _____ Zip _____ Phone _____

Referred by: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this healthcare office will be credited to my account upon receipt. However, I clearly understand and agree that any services rendered me and charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ Initials

Please Hand the Front Desk Personnel a Copy of Your Insurance Card

Patient's Signature _____ Date ___/___/___/

Name _____ Date _____ ID# _____

Describe your symptoms:

How did your symptoms begin? _____

Are your symptoms : Improving Getting Worse Same

RELEVANT MEDICAL HISTORY (Check if you have had in the past or present)

<input type="checkbox"/> Arthritis/Osteoporosis	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Psychological problems
<input type="checkbox"/> Asthma/Sinus trouble	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Neck pain or spasms
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hand or wrist pain	<input type="checkbox"/> Neuritis/Numbness/Neuro disorders
<input type="checkbox"/> Back pain/Sciatica	<input type="checkbox"/> Headaches	<input type="checkbox"/> Thyroid or menstrual problems
<input type="checkbox"/> Concussion/Dizziness	<input type="checkbox"/> Hepatitis/Measles/T.B.	<input type="checkbox"/> M.S./Muscular dystrophy
<input type="checkbox"/> Digestion problems	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/Aids/Blood infections	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Heart	<input type="checkbox"/> Cancer	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Gout	<input type="checkbox"/> Healing	<input type="checkbox"/> Frequent infections
<input type="checkbox"/> Kidneys	<input type="checkbox"/> Skin	<input type="checkbox"/> Liver
<input type="checkbox"/> Lungs	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bladder
<input type="checkbox"/> Hormones	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Deep vein thrombosis

Do you have any artificial joints? Hip Yes ___ No ___ Knee Yes ___ No ___ Other? _____

Do you have a Heart Valve Implant? Yes _____ No _____

FAMILY HISTORY:

	Diabetes	Cancer	Heart	Lung	Thyroid	Living	Deceased	Cause
Mother								
Father								
Brother								
Sister								

Is there a family (blood relative) history of:

- Flatfeet
- Arthritis
- Stroke
- Bunions
- Diabetes
- Heart Disease
- Bleeding disorder
- Neurological disorder
- Hammertoes
- Circulation problems

Allergies to Medications:

SOCIAL HISTORY:

- Smoking history:**
 never smoked
 quit (how long ago _____)
 Smoke _____ pks/day for _____ yrs
- Alcohol History:**
 Never used
 Have _____ drinks/week
 have drank alcohol for _____ yrs

ADDITIONAL HISTORY:

Previous surgeries or hospital stays; Any recent exposures to communicable diseases or other concerns:

 Instructed to see PCP

Have you been treated for any health conditions in the past year?

Have you ever seen a chiropractor? Yes No If yes, who? _____
 For Podiatry patients; Shoe Size? _____

Additional Information:

Patients Signature _____

Date ____ / ____ / ____

