

# Wasilla Physical Therapy

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ DOB \_\_\_\_\_ SSN# \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced/Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

I would like appointment reminder sent via (circle one) E-Mail \_\_\_\_\_

Cell \_\_\_\_\_ Carrier \_\_\_\_\_

## RESPONSIBLE PARTY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Relation to Patient \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

SECONDARY Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

\*Workmans Comp claim # \_\_\_\_\_ Auto Accident claim # \_\_\_\_\_ Date of Injury \_\_\_\_\_

## GENERAL INFORMATION

Emergency Contact information

Name \_\_\_\_\_ Phone/Cell \_\_\_\_\_ Relationship \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Referring Physician \_\_\_\_\_

Who in your family may we discuss your health care with?

\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Wasilla Physical Therapy (WPT) FINANCIAL POLICIES**

**PLEASE REVIEW AND INITIAL**

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

- If proof of insurance cannot be provided, payment will be due in full. \_\_\_\_\_
- Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, “usual and customary” charges, etc. other than to supply required information.
- Any balances on your account need to be paid in full before you will be seen again, unless a payment arrangement has been made with the billing personnel. \_\_\_\_\_
- WPT bills secondary insurance only when required by contract: Medicare, Medicaid, Blue Cross, Tricare, and Aetna. \_\_\_\_\_
- Delinquent account (>90 days) are subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged by CCS. Patients whose accounts have been sent to CCS will be discharged from the clinic. \_\_\_\_\_
- WPT will charge a fee of \$30.00 for any checks marked NSF from the bank. It is also the policy of WPT that the patient’s account be flagged until the debt has been repaid. Remittance should be in the form of cash, credit card, or money order along with the NSF Fee. \_\_\_\_\_
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time is subject to a \$40.00 appointment cancellation fee. \_\_\_\_\_
- I hereby assign all medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Wasilla Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance (including Medicaid). I hereby authorize assignee to release all information needed to secure the payment, and necessary medical correspondence required for treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Current Medications**

Name of Drug	Dose (include strength and number of pills per day)	Prescribed by

**Medical History**

Do you now or have you ever had:

<input type="checkbox"/> Diabetes (type) _____ <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart problems <input type="checkbox"/> Pneumonia <input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Gallstones <input type="checkbox"/> Migraines <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other: <hr/> <hr/> <hr/>
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**ALLERGIES:**

Surgical History (include date of surgery)	Hospitalizations (include dates and reason)

Family History	Check One			Health issues / Cause of death if deceased
	Alive		Deceased	
<b>Father</b>				
<b>Mother</b>				
<b>Paternal Grandfather</b>				
<b>Paternal Grandmother</b>				
<b>Maternal Grandfather</b>				
<b>Paternal Grandfather</b>				

<b>Siblings:</b>	Brothers	Sisters	Sons	Daughters
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**Marital Status:** \_\_\_\_\_

<b>Mold/Mildew Exposure</b>	Yes	No
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<b>Tobacco use</b>	Yes	No	How many/often?
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<b>Alcohol use</b>	Yes	No	How many/often?
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**Drug use (specify):** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## OPTIMAL INSTRUMENT Difficulty – Baseline

Instructions: Please Mark an "X" for the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat						
2. Rolling over						
3. Moving–lying to sitting						
4. Sitting						
5. Squatting						
6. Bending/Stooping						
7. Balancing						
8. Kneeling						
9. Standing						
10. Walking – Short Distance						
11. Walking – Long Distance						
12. Walking – Outdoors						
13. Climbing Stairs						
14. Hopping						
15. Jumping						
16. Funning						
17. Pushing						
18. Pulling						
19. Reaching						
20. Grasping						
21. Lifting						
22. Carrying						

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 13 2. 8 3. 14 )

1. \_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. *13*)

Primary goal. \_\_\_\_

The OPTIMAL may be used without permission or restriction per our website, [www.apta.org/optimal](http://www.apta.org/optimal). Please note, however, that it remains the copyrighted intellectual property of *Physical Therapy* (PTJ) and the following citation must be included for all uses:

# Marketing Survey

Wasilla Physical Therapy would like to know how you found out about us. Please place a check mark on all that apply and fill in the information.

**Medical Referral** – Please write the Physician's name or Nurse Practitioner's name

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**Patient Referral** – Please write person's name

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**TV Commercial** – Which channel did you see Wasilla Physical Therapy

- |                                            |                                       |                                   |
|--------------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Channel 13 - KTVA | <input type="checkbox"/> Food Network | <input type="checkbox"/> FOX News |
| <input type="checkbox"/> CNN               | <input type="checkbox"/> Discovery    | <input type="checkbox"/> A&E      |
| <input type="checkbox"/> CMT               | <input type="checkbox"/> OWN          | <input type="checkbox"/> History  |
| <input type="checkbox"/> HGTV              | <input type="checkbox"/> ESPN         | <input type="checkbox"/> Other    |
- 

## **Print Advertisement**

*Please check all that apply*

- |                                                      |
|------------------------------------------------------|
| <input type="checkbox"/> Frontiersman                |
| <input type="checkbox"/> Health and Fitness Guide    |
| <input type="checkbox"/> Medical Guide Advertisement |
| <input type="checkbox"/> WPT Brochure/Flyer          |

## **Radio Advertisement**

*Please check all that apply*

- |                                                               |
|---------------------------------------------------------------|
| <input type="checkbox"/> JBER Relocation Guide                |
| <input type="checkbox"/> Chamber of Commerce Relocation Guide |
| <input type="checkbox"/> KMBQ                                 |
| <input type="checkbox"/> Country Legends                      |

**Did you visit our website?**

Yes  No

How useful was our website at helping you make the decision to have WPT be your physical therapy provider? (Please rate from 1 to 5, 5 being the highest)

1  2  3  4  5

**Thank you!**