VB Physical Therapy

619 Fayetteville Road

Van Buren, AR 72956

Patient Information

First Name _____ Last Name _____Birthday _____/____/_____

Address _____ City _____ State _____ Zip code_____

Social Security Number _____ - _____ - _____

Cell Phone _____ Alternate Phone _____ (Home, work, other)

Parent Name (If patient is minor) _____ Parent Birthday (If patient is minor) _____/_____/_____

Problem

Injury/Body Part(s) _____ Date of Surgery/Injury_____

How did injury occur : _____

_____

Referring Provider _____ Primary Care Physician _____

Medical Insurance Information

Primary Insurance: _____

If you are not the subscriber please list name and date of birth of the person who is:

_____

Secondary Insurance: _____

Workers Compensation: _____

Motor Vehicle Accident: _____

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Medical Questionnaire

Have you recently had other treatment for your pain? _____

Have you recently had an X-ray, MRI, CT scan? (If so when)_____

Are you currently receiving any home health services? _____

How would you rate your general health? _____good _____fair _____poor

Medical History (Check all that apply)

- ☐ Allergies
- ☐ Asthma
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Cancer
  Type _____
- ☐ Diabetes
  Type 1 or Type 2
- ☐ Dizziness/Vertigo
- ☐ Fibromyalgia
- ☐ Other

_____

_____

- ☐ Fracture
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Loss of balance/falls
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Seizures

Signature: _____ Date: _____

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No Show Fee Policy:

We schedule our appointments so that each patient receives the right amount of time to be seen by our staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

If you do not cancel or reschedule your appointment before your allotted time, we will assess a $30 "no-show" fee. This "no-show" fee is not reimbursable by your insurance company. You will be billed directly for it.

Privacy Policy:

I consent to the use or disclosure of my protected health information (PHI) by VB Physical Therapy for the purpose of treatment, payment, and Health Care Operations. I have read a copy of the Notice of Privacy Practices: HIPAA and understand I have a right to review it prior to signing this document.

Patient Name:_____

Signature: _____ Date:_____