Panther Physical Therapy & Sports Performance
5935 S. Zang Street Unit 9,
Littleton CO 80127
phone: 303-979-5511
fax: 303-979-6469
http://www.pantherphysicaltherapy.com

DEMOGRAPHIC INFORMATION

Patient Full Name (F, MI, L): _____ SSN:_____

Name Preference:_____ Date Injured: _____Date of Surgery_____

Address: _____ Date of Birth: _____Age: _____Sex: M F

City: _____State: _____Zip: _____ Home #_____Cell #_____

Email Address: _____ How did you hear about us?_____

Referring Dr:_____ Injury/Diagnosis:_____

Primary Care Physician:_____ PCP Phone Number:_____

Employer: _____ Employer Address: _____

Employer Phone #_____ City: _____ State: _____Zip: _____

Guarantor Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone #:_____

Address if different: _____ City: _____State:_____ Zip: _____

INSURANCE INFORMATION:

For Private, Medicare, or Government Providers: Please present Insurance ID card to front desk.

*If you are being seen for an injury related to **work comp or an auto accident,** please give the name of the insurance carrier responsible.*

Workers Comp: Y N Auto: Y N

Insurance Company: _____

Adjuster Name: _____ Phone # _____

Claim #: _____

MEDICAL HISTORY

Height: _____ Weight: _____

Do you have, or have you ever had any of the following?

Heart problems/pacemaker	Y N	History of falls	Y N
Lung/breathing problems	Y N	Arthritis	Y N
Diabetes	Y N	Osteoporosis/Osteopenia	Y N
Cancer	Y N	Dizziness	Y N
High BP	Y N	Fainting	Y N
Asthma	Y N	Seizures	Y N
Blood Disorders	Y N	Unexplained weight loss	Y N
Hepatitis	Y N	Circulation problems	Y N

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Any other Medical History?

_____

_____

Do you currently have or have you had any of the following symptoms related to your injury?

Arm/Leg Swelling	Y N	Joint/Muscle Swelling	Y N	Problems Sleeping	Y N
Constipation/Diarrhea	Y N	Nausea/Vomiting	Y N	Problems Urinating	Y N
Fever/Chills/Sweats	Y N	Numbness/Tingling	Y N	Unusual Fatigue	Y N

If Yes to any of the above please explain:_____
_____
_____

Any previous surgical procedures and or significant injuries? _____

_____

_____

Medications currently taking (prescription, over the counter, pills, injections, patches, vitamins, herbs?

_____

_____

Allergies (medications, food intolerances, latex, etc.?_____

_____

_____

Do you participate in any sports, exercise programs or activities on a regular basis? _____

_____

Anything else you want us to know?_____

Emergency contact: Name: _____ Relationship: _____ Phone #:
_____

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CONSENT TO TREAT AND HIPAA ACKNOWLEDGEMENT

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. I have read and understand the terms outlined above and consent to all necessary treatment as determined by Panther Physical Therapy.

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. I will be given a copy of the privacy practices upon request.

Patient Name: _____ Signature/Guardian:_____

Date:_____

CANCELLATION POLICY/NO SHOW POLICY

Thank you for choosing Panther Physical Therapy as your physical therapy provider. We are sincerely dedicated in assisting you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in **quicker recovery and better outcomes.**
We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that slot for another client.
If you are calling after hours you may leave a message at 303-979-5511.

24 HOUR NOTICE
In order to enforce this policy, you will be charged $50.00 for an appointment cancelled without 24 hour notice. (If that appointment slot gets filled by another patient we will waive the charge.)

NO CALL/ NO SHOW
If you do ***not show up*** or ***call to cancel*** an appointment you will be charged $80.00 payable at your next visit.

Canceling appointments without 24 hour notice and no shows more than ***3 times*** will unfortunately limit your ability to schedule advanced appointments and will result in ***same day scheduling***.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very important part of this. If you know you are going to have a difficult making your appointments, please discuss this with your therapist.

Thank you

Patient/Parent/Legal Guardian Signature_____

Print Name_____Date:_____