Terrapin Care Center
9658 Baltimore Avenue, Suite 420, College Park, MD
Tel: 301.220.1930 • Fax: 301.220.1906
www.terrapincarecenter.com

SECTION 1. ABOUT YOU

Today's Date: _____ / _____ / _____

Name: (Last) _____ (First) _____ (Mid. Init.) _____

Birthday: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female Social Security #:_____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ E-mail Address: _____

Phone #:** ☐ Home _____ ☐ Cell _____ ☐ Work _____

Employer: _____ Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

If Married, Spouse's Name: _____ # of Children: _____

Emergency Contact: _____ Phone #: _____

Whom may we thank for referring you? _____

**Optional **Check best contact number*

SECTION 2. PAYMENT (select one)

☐ **Insurance** Primary Carrier: _____ Policy #: _____

Insurer's Name: _____ Insurer's DOB: _____ / _____ / _____

Secondary Carrier: _____ Policy #: _____

Insurer's Name: _____ Insurer's DOB: _____ / _____ / _____

☐ **Auto/Personal Injury** Auto Insurance Carrier: _____ Policy #: _____

Claim #: _____ Adjuster's Name: _____

Adjuster's Ph. #: _____ Adjuster's Fax #: _____

Attorney Name (*If Applicable*): _____ Attorney Phone #: _____

☐ **Selfpay** ☐ **Other** *(Please Specify)* _____

SECTION 3. HEALTH HISTORY

Primary Care Physician: _____ Phone #: _____

Other Treating Specialists: _____ Phone #: _____

Are you Taking Any Medications? ☐ Yes ☐ No If yes, please list: _____

Medication	Dosage	Frequency	Prescriber

Have you ever had any diagnostic imaging? ☐ Yes ☐ No If yes, please list:

Imaging Type	Body Part	Date	Location
X-RAY			
MRI			
CT SCAN			

(Please notify the receptionist if you listed any imaging so that we may obtain the report. This will provide our doctors with more information regarding your condition and ensure the highest level of care.)

Please list any other recent diagnostic testing (i.e., Bloodwork): _____

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SECTION 3. HEALTH HISTORY (CONTINUED)

Do you have or ever had any of the following diseases or conditions? *(mark: **y** for yes **n** for no)*

☐ Alcohol/drug abuse	☐ Diabetes/tuberculosis	☐ Heart murmur	☐ Lower back problems	☐ Snoring
☐ Anemia	☐ Difficulty breathing	☐ Heart surgery/pacemaker	☐ Mitral valve prolapse	☐ Ulcer/colitis
☐ Arthritis	☐ Dislocations	☐ Hepatitis	☐ Psychiatric problems	☐ Venereal disease
☐ Artificial bones/joints	☐ Emphysema/Glaucoma	☐ Herniated Disc	☐ Rheumatic fever	
☐ Artificial valve	☐ Fainting/seizures/epilepsy	☐ High/low blood pressure	☐ Sciatica	Weight:
☐ Asthma	☐ Fractures	☐ Joint Pain	☐ Severe/frequent headaches	Height:
☐ Cancer/Chemotherapy	☐ Frequent neck pain	☐ Kidney problems	☐ Shingles	
☐ Congenital heart defect	☐ Heart attack/stroke	☐ Leg/Arm Pain	☐ Sinus problems	

List any other serious medical condition(s) that we should know about: _____

_____

List any past serious accidents or surgeries and include the dates: _____

_____

List allergies: _____

_____

Do you exercise? ☐ Yes _____times/day ☐ No What exercise activities do you do? _____

Do you: • smoke? ☐ Yes _____times/day ☐ No • drink alcohol? ☐ Yes _____times/week ☐ No • drink coffee? ☐ Yes _____cups/day ☐ No

Do you take supplements (i.e. vitamins, minerals, herbs)? List them: _____

FOR WOMEN: Have children? ☐ Yes ☐ N Taking birth control? ☐ Yes ☐ No Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

SECTION 4. REASON FOR VISIT

The reason for this visit is a result of ☐ Work ☐ Auto ☐ Trauma ☐ Chronic ☐ Other *(Explain)*: _____

_____

Please describe the pain and its location: _____

When did the condition begin? _____ This condition is: ☐ Constant ☐ Intermittent ☐ Activity related

Condition is interfering with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily routine If so please explain: _____

What activities aggravate your symptoms? _____ Condition getting worse? ☐ Yes ☐ No

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No *(Describe)* _____

Have you experienced this condition before? ☐ Yes ☐ No If so please explain: _____

Who have you seen for this? _____

What did they do? _____ How did you respond? _____

Are there activities you cannot do as a result of your problem/pain? ☐ Yes ☐ No *(Describe)* _____

What is your goal here at Terrapin Care Center? _____

Is there any time during the day that you have no pain? ☐ Yes ☐ No

	1= No pain									10= Worst pain imaginable
Please circle the number corresponds with your pain today overall.	1	2	3	4	5	6	7	8	9	10
Please circle the number corresponds with your pain at its worst.	1	2	3	4	5	6	7	8	9	10

Do you ever experience numbness or tingling in your hands/feet? ☐ Yes ☐ No

Do you snore at night? ☐ Yes ☐ No Do your feet ever bother you? ☐ Yes ☐ No

Is there any anything else we should know or you'd like to add? _____

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SECTION 5. KNEE PAIN QUESTIONNAIRE (IF APPLICABLE)

Have you been diagnosed with Osteoarthritis of the knees ☐ Yes ☐ No If yes, which knee? ☐ Right ☐ Left ☐ Both

Have you tried the following for your knee pain:

Physical Therapy ☐ Yes ☐ No If yes, how effective was it? ☐ Very Effective ☐ Effective ☐ Somewhat Effective ☐ Not Effective

Non-steroidal Anti-inflammatory Drugs (NSAIDs) ☐ Yes ☐ No If yes, which kind and how often? _____

Hyaluronic Acid injections ☐ Yes ☐ No If yes, which kind? ☐ Synvisc ☐ Orthovisc ☐ Supartz ☐ Hyalgan ☐ Euflexxa ☐ Other

Date of last injection? _____ Number of injections received? _____

Physician's name _____ Phone # _____

How effective was it? ☐ Very Effective ☐ Effective ☐ Somewhat Effective ☐ Not Effective

Knee surgery/replacement ☐ Yes ☐ No If yes, which knee? ☐ Right ☐ Left ☐ Both Date of surgery? _____

How effective was it? ☐ Very Effective ☐ Effective ☐ Somewhat Effective ☐ Not Effective

SECTION 6. RADIOGRAPH CONSENT, APPOINTMENT POLICY, AUTHORIZATION FOR TREATMENT

I _____ hereby give my consent to allow Terrapin Care Center and it's representatives as deemed by the examining physician to take radiographs (x-rays) of my spine and/or extremities

For Women: I also hereby declare that to my knowledge I am not pregnant _____ (Initial)

Signature of Patient or Guardian of said Minor _____ Date _____

Missed appointments without prior notification will result in a $25.00 cancellation fee. We apologize for any inconvenience this may cause, but each patient's time with the doctor/therapist is valuable. If you need to reschedule your appointment, kindly give us a courtesy phone call, so we are able to open up the timeslot for other patients.

Signature of Patient or Guardian of said Minor _____ Date _____

I authorize and agree to allow the doctor and/or physical therapist to examine and treat me for the purpose of pain management, postural and structural restoration of normal biomechanical, and neurological function.

The doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the medical and spinal structural conditions diagnosed at this clinic.

I authorize the assignment of all insurance benefits to be directed to the doctor and/or physical therapist for all services rendered.

Signature of Patient or Guardian of said Minor _____ Date _____

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SECTION 7. NOTICE OF PRIVACY PRACTICES

The following authorizes Terrapin Care Center to use and/or disclose protected health care information in accordance with the following specific authorizations:

By signing the following you are giving Terrapin Care Center permission to use and disclose your protected health information in accordance with the directives listed in the "Authorization for Treatment" section

Acknowledgement of Receipt & Notice of Privacy Practices:

Information you provide may be used for:

- Treatment
- Payment
- Appointments

I _____ understand and have been provided with a notice of information practices that provides me with a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health care information for directory purposes
- The right to request restrictions as to how my health care information may be used or information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Signature of Patient or Guardian of said Minor _____ Date _____

SECTION 8. PAYMENT POLICY, INSURANCE POLICY

In order to keep our fees from rising and at the same time keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients these payment policies.

1. Payment is expected at the time services are rendered. Our office accepts cash, Visa, Mastercard, Discover, American Express, and checks.
2. Non-insured patients are expected to make payments in full on the day the service is rendered, unless definite arrangements have been made with the doctor in advance.
3. Patients with insurance are expected to pay their patient portion of the total fee not covered by their insurance on the day of service. This "patient portion" is ONLY an estimated dollar amount.
4. At your request, the doctor will discuss the charges with you before care begins.

We bill patients on a monthly basis. All accounts not paid within 90 days will automatically be put through to an outside collections agency, which may affect your credit. In case of financial difficulty, please let us know so that a manageable payment schedule can be worked out.

Signature of Patient or Guardian of said Minor _____ Date _____

1. You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy. As a COURTESY, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; however, the payment is ultimately your responsibility.
2. All deductible payments must be made prior to insurance submittal. Please contact your insurance company to verify your coverage.
3. All co-payments must be paid in full at the time of service.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
5. This office does not promise that insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

Signature of Patient or Guardian of said Minor _____ Date _____