Golden Plains Community Hospital Rehabilitation
Personal Information Form (Please Print)

Patient Name: (Last, First, MI)		
Sex: M or F	Marital Status:	DOB:
Mailing Address:	City, State, Zip	
Social Security Number:	Home Phone:	
Employer:	Cell Phone:	
Employer Address:	Work Phone:	

Referring Doctor: (Name, Location):
Family Doctor: (Name, Location):
Emergency Contact/Relation/Phone:

Primary Health Insurance:
Secondary Health Insurance:

Golden Plains Community Hospital
Rehabilitation Department
100 Medical Drive
Borger, Texas 79007

By signing below, I certify the above information is correct

X____ Date: ______________

GOLDEN PLAINS COMMUNITY HOSPITAL
PATIENT HISTORY

Name ____

Are you a home health patient? ☐ Yes ☐ No

How did you hear about Golden Plains Rehabilitation Center?

Physician Newspaper Previous care here at GPCH

Family/Friends TV/Radio Other

1. **What is your main complaint or problem?**

   Date of onset? ________________ How did it occur? ________________

   ____

   Date of surgery? ________________ Type of surgery? ________________

2. **If you have pain, please circle those words that best describe it.**
   Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache
   Numb Tingle Tight Pulling

3. **Please rate the level of your pain at its best and worst.**

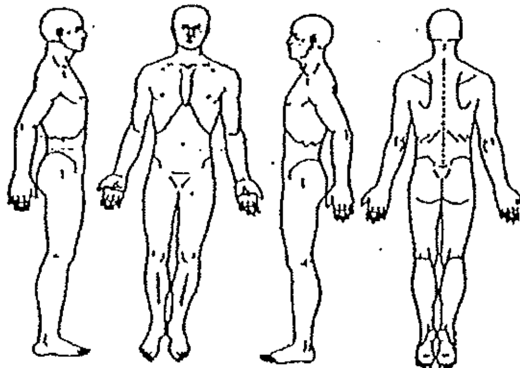
0 1 2 3 4 5 6 7 8 9 10
←No pain--Extreme Agony →

4. **How do you feel in the: Morning?** Better / Worse **Afternoon?** Better / Worse **Evening?** Better / Worse **Night?** Better / Worse

5. **What positions o r activities make your pain better?**

6. **What positions or activities make your pain worse?**

7. **Please indicate painful areas by shading models.**



8. **What tests and/or treatments have you had for this problem? What were the findings?**

X-Ray: CT Scan:
EMG: Myelogram:
MRI: Other:

9. **Please list the Medications you currently take & why *OR* attach list**

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10. **What is your occupation?** ______________________
    a. **Working:** Full-Time Part -Time Light Duty Not Working
    b. **Physical Work Requirements:** Sedentary Light Moderate Heavy
    c. **Job requires prolonged:** Sitting Standing Bending Walking Lifting Squatting Driving

11. **What functional activities are you currently having problems with?**
    Dress/Bathe Job Duties Housework Cook/Eat Walk Stand Sit Drive Sleep Recreation

12. **Do you have another appointment with your doctor, and if so when?**
    Yes No

13. **What do you hope to accomplish with physical therapy treatment?**

14. **Do you have any medical problems/conditions?**

	YES	NO	Comments/Reactions
Heart Problems			
Blood Pressure			
Diabetes			
Medication Allergies			
Allergies			
Latex Allergy			
Arthritis			
Seizures			
Pregnant			
Osteoporosis			
Cancer			

Patient Label

GOLDEN PLAINS COMMUNITY HOSPITAL

CONDITION OF ADMISSION

AUTHORIZATION FOR TREATMENT AND /OR SURGERY

'he patient and others whose signatures are attached below do hereby consent to any and all medical surgical treatments, including anesthetics and operations, vhich may be deemed advisable by his or her physicians or surgeons serving on the staff of Golden Plains Community Hospital, the intention hereof being to grant uthority to administer and to perform all and singular examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the ourse of the patients care be deemed advisable or necessary. We also agree that the patient when admitted is to remain in the HOSPITAL until his or her physicians ecommend the patient's discharge, and when the physicians decide that the patient no longer needs HOSPITAL care, we consent to and authorize patient's transfer o his or her home or place of abode. In witness of our consent and agreement of the matters stated in the two preceding sentences, we have subscribed our ignature below.

ASSIGNMENT OF BENEFITS – HOSPITAL

'We hereby transfer, assign and convey all my/our rights, title and interest in and all benefits due me/us, if any, by reason of services described in the statements endered, and as provided for in any contract or policy of insurance under which I/we may be an insured or beneficiary and I direct said insurance company(s) to pay irectly to Golden Plains Community Hospital, at Borger, Hutchinson County, Texas, all of such benefits. I/We also assign my/our causes of action against any and all hird parties who may be responsible or liable for the injuries requiring admission to or treatment by Golden Plains Community Hospital, up to but not to exceed the mount of charges described in the statements rendered. I agree to pay the HOSPITAL any remaining balance after insurance payment or denial of coverage under 1is assignment of benefits.

AUTHORIZATION TO RELEASE INFORMATION

authorize that any medical, mental health, HIV testing and status, and/or substance abuse information be released. I understand and agree that no liability of any ature shall attach to the releasing organization or person, to any physician or surgeon in release of this information, or to any employee of them acting upon this equest.

ASSIGNMENT OF BENEFITS – PHYSICIANS

agree to be primarily responsible for payment of physician(s) charges. I also assign to my physician(s) my right to all applicable insurance benefits and my cause(s) of ction against any third party responsible or liable for the condition or injuries requiring physician services. I grant the physician(s) a lien against all settlement roceeds or recovery by judgment from any such third party – up to but not to exceed the amount of the physician's charges and reasonable attorney fees.

MEDICARE ASSIGNMENT AND AUTHORIZATION

certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other formation to release to the Social Security Administration, Health Care Financing Administration or their intermediaries any information needed for this or any lated Medicare claim. I request that payment of authorized benefits be made on my behalf.

PATIENT VALUABLES

l parties are advised that valuables should not be kept in their respective HOSPITAL room. Proper and safe facilities for any valuables are offered by the HOSPITAL. 1e HOSPITAL is not responsible for valuables not properly registered. The HOSPITAL cannot be held responsible for personal belongings and it is strongly urged that ou not keep any personal items of significant value in your room.

AUTHORIZATION/PRECERTIFICATION

my group or private insurance policy requires prior certification, authorization, second opinions, or any other types of utilization review function, I understand that I n responsible for compliance with these and all other terms of my policy.

PATIENT FINANCIAL RESPONSIBILITY

ie HOSPITAL's election to pursue one or more forms of collection shall not constitute a waiver of its right to pursue other collection measures it deems advisable or cessary. All such remedies shall be cumulative in nature. Venue for collection shall be Hutchinson County, Texas. This agreement shall not require payment any rson in contravention of any state or federal statue, rule or regulation.

__________ I have read/received a copy of the PATIENT RIGHTS AND RESPONSIBILITIES.

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;nature of Patient or Legally Authorized Representative Date Registration Clerk Signature

ADVANCE DIRECTIVES

you have an Advance Directive?	Yes_____	No_____	Booklet Given_____
claration for Mental Health?	Yes_____	No_____	Booklet Given_____

'es, please give a copy to your RN.