

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name Last First MI			<input type="radio"/> Female <input type="radio"/> Male		Patient date of birth		
Patient address				City	State	Zip code	
Patient insurance ID#		Health plan		Group number			
Referring physician (if applicable)			Date referral issued (if applicable)		Referral number (if applicable)		

Provider Information

Dr. Robert Weissfeld

1. Name of the billing provider or facility (as it will appear on the claim form) **Robert Weissfeld DC**

2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 **2775 S. Broadway**

5. NPI of entity in box #1 **1487629432**

6. Phone number **303-300-3933**

7. Address of the billing provider or facility indicated in box #1 **Englewood**

8. City **CO**

9. State **80113**

10. Zip code

Provider Completes This Section:

Date you want THIS submission to begin:

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Cause of Current Episode

(1) Traumatic (4) Post-surgical
 (2) Unspecified (5) Work related
 (3) Repetitive (6) Motor vehicle

Date of Surgery

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Type of Surgery

(1) ACL Reconstruction
 (2) Rotator Cuff/Labral Repair
 (3) Tendon Repair
 (4) Spinal Fusion
 (5) Joint Replacement
 (6) Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1°

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2°

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3°

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4°

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Nature of Condition

(1) Initial onset (within last 3 months)
 (2) Recurrent (multiple episodes of < 3 months)
 (3) Chronic (continuous duration > 3 months)

DC ONLY Anticipated CMT Level

98940 98942
 98941 98943

Current Functional Measure Score

Neck Index

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 DASH

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 (other)

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Back Index

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 LEFS

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Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

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1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time)
 (2) Frequently (51%-75% of the time)
 (3) Occasionally (26% - 50% of the time)
 (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all
 (2) A little bit
 (3) Moderately
 (4) Quite a bit
 (5) Extremely

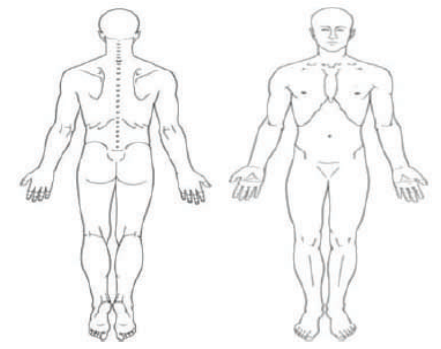
6. How is your condition changing, since care began at this facility?

(0) N/A — This is the initial visit
 (1) Much worse
 (2) Worse
 (3) A little worse
 (4) No change
 (5) A little better
 (6) Better
 (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent
 (2) Very good
 (3) Good
 (4) Fair
 (5) Poor

Indicate where you have pain or other symptoms:



Patient Signature: X **Date:** _____