PATIENT REGISTRATION FORM

Patient Name: ______________________________________ Date of Birth: _______/______/______ Age: _____________

Address: ____________________________ City: __________________________ State: _______ Zip: _____________

Home Phone: (____) ______________________________ Work/Alternate Phone: (____) _______________________

Employer: ______________________________________ Male □ Female □ SSN#: _______-_______ -__________

Referring Physician: ______________________________ Physician Phone: (____) ____________________________

Primary Care Physician: ___________________________ Physician Phone: (____) ____________________________

***Are you currently receiving any type of Homecare? (Nursing, O/T, P/T) _____ YES _____ NO Date Last Seen _____/____/_______**

INSURANCE INFORMATION

Primary Insurance: ____

Policy Holder's Name: _________________________ Policy Holder Birth Date: ______/_________/_________

ID #: ____ Group #: _______________________

Secondary Insurance: ____

Policy Holder's Name: _________________________ Policy Holder Birth Date: ______/_________/__________

ID #: ____ Group #: _____________________

Is this problem related to a Motor Vehicle Accident (please circle) YES / NO or Work Injury YES / NO? If you answered YES to either of the above, please complete the following insurance information.

Worker's Compensation Carrier: _________________________________ Phone #: (____) _____________________

Address: _________________________________ City: ___________________ State: _____ Zip: _________________

Adjustor's Name: _______________________ Claim #: __________________ Date of Injury: _______/_______/________

Attorney Name: ____________________________________ Telephone Number: (____) ___________________

Address: _________________________________ City: ___________________ State: _____ Zip: ________________

I, __________________________, wish to have physical therapy services provided to me by Patriot Physical Therapy, I have received the "Notice of Privacy Policies," and I authorize the release of any information necessary to process my Insurance Claims and request payment directly to Patriot Physical Therapy. ***** IN THE EVENT THAT MY INSURANCE IS DENIED OR CANCELLED, <u>I WILL BE RESPONSIBLE FOR PAYMENT</u> OF CHARGES INCURRED FOR MY PHYSICAL THERAPY SERVICES. *****

Signature Required for Consent: ______________________________________ Date: _____________

Authorization for the treatment of minors

I hereby authorize Patriot Physical Therapy to perform Physical Therapy on the minor named herein _______________________ of the parent or guardian named herein __________________________________.

Patriot Physical Therapy will charge a $25.00 fee for "No Show" visits

I have read this statement and understand that a fee will be charged to me for any visit not cancelled (1) one hour prior to my scheduled appointment time. **Signature:** ____

Medicare Authorization

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare Claim. I request payment of authorized benefits be made on my behalf.

Signature of Medicare Patient: ____

*HOW DID YOU HEAR OF PATRIOT PHYSICAL THERAPY? ____

PATRIOT PHYSICAL THERAPY
GENERAL MEDICAL HISTORY

General Information

Date:

Last Name First Name

Relationship:

Emergency Contact Phone

Are you currently working? (Y) (N) Type of Work:

If not, why?

General Medical History:

The information requested may be needed if you have a medical emergency.

Please check if you have been treated for:

( ) Heart Problems
( ) Pace Maker
( ) Fainting of Dizziness
( ) Shortness of Breath
( ) Calf Pain with Exercise
( ) Severe Headaches
( ) Recent Accident
( ) Head Trauma/Concussion
( ) Muscular Weakness
( ) Cancer
( ) Joint Dislocation
( ) Broken Bone
( ) Difficulty Sleeping
( ) Frequent Falls
( ) Unexplained Weight Loss
( ) Tremors
( ) High Blood Pressure
( ) Kidney Disease
( ) Weakness or Fatigue
( ) Hernias
( ) Blurred Vision
( ) Bowel/Bladder Problems
( ) Night Pain (While Sleeping)
( ) Any Infectious Disease (TB, AIDS, Hepatitis)
( ) Constant Pain or Pressure During Activity
( ) Tingling, Numbness, or Loss of Feeling? If yes, where?
( ) Difficulty Swallowing
( ) A Wound that won't heal
( ) Unusual Skin Discoloration
( ) Lung Disease/Problems
( ) Arthritis
( ) Swollen/Painful joints
( ) Irregular Heart Beat (Murmur)
( ) Stomach pains or Ulcers
( ) Pain with Cough or Sneeze
( ) Back of Neck injuries
( ) Diabetes
( ) Stroke
( ) Balance problems
( ) Muscular Pain with Activity
( ) Swollen Ankles or Legs
( ) Jaw Problems
( ) Circulatory Problems
( ) Epilepsy/Seizures/Convulsions
( ) Chest Pain or Pressure at Rest
( ) Allergies (Latex, Medication, Food)
( ) Constant Pain Unrelieved by Rest
( ) Pregnancy
( ) Nervous or Emotional Problems

Do you use tobacco? (Y) (N) If yes, how much?

Are you presently taking any medications or drugs? (Y) (N)

If yes, what are you taking them for? _ High Blood Pressure _ Diabetes _ Heart
_ Pain/Inflammation _ Other

1. Pain

On a scale of 0 to 10, with 0 being no pain, and 10 being the worst pain imaginable, give yourself a score for your **current level** of pain__________

2. Simple Movements (moving your involved region)

On a scale of 0 to 10 with 0 being normal movement of your involved region and 10 being unable to move your involved region at all, give yourself a score for your current ability to perform simple movements with your involved region ___________

3. Function (getting out of a bed or chair, driving, getting dressed, etc)

On a scale of 0 to 10 with 0 being able to perform all of your normal daily activities, and 10 being that you are unable to perform any of your normal daily activities, give yourself a score for your current ability to perfom your activities of daily living ____________

Please list any major sugery or hospitalization:

Hospital: ________________________________ Approx. Date: _________________________________

Reasons: ____

Hospital: ________________________________ Approx. Date: _________________________________

Reasons: ____

Have you recently had an X-ray, MRI, or CAT scan for your condition? (Y) (N)

Facility: ______________________________ Approx. Date: ___________________________________

Findings: ____

Please mention any problems or symptoms you feel are important: _____________________________

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Have you been evaluated and/or treated by another physician, physical therapist, chiropractor, osteopath or health care practitioner for this condition? (Y) (N) If yes, please circle which one.

I, the undersigned, state that I have answered this form to the best of my knowledge.

Patient Signature: ____ Date: ________________________

THANK YOU FOR TAKING TIME TO PROVIDE US WITH THIS INFORMATION