

PATIENT REGISTRATION

Patient Information:

Name (Last, First): _____ Date: _____

Nickname: _____ Marital Status: _____

Birth Date: ____/____/____ Age: _____ Sex(Circle One): (Male / Female)

Address: _____
Street Apt/Unit City State Zip Code

Phone: _____ #: _____ #: _____
Home Cell Work

Email: _____

How would you like to receive appointment reminders? ***Check off preference(s)*** Text: ___ Call: ___ Email: ___

Race: ___ African American ___ Asian ___ White ___ Other: _____
___ American Indian/Alaskan Native ___ Native Hawaiian/Other Pacific ___ Patient declined and/or unable to provide

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Insurance Information: ****ONLY FILL OUT IF YOU DID NOT BRING INSURANCE CARDS****

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Physician Information:

Name of Primary Care Physician: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Phone (Home): _____ (Cell): _____

Legal:

Is this visit a result of a motor vehicle accident: ___ Yes ___ No Date of Injury: _____

Is this visit a result of a work-related injury: ___ Yes ___ No Date of Injury: _____

Is this visit a result of other legal injury: ___ Yes ___ No Date of Injury: _____

How did you hear about us? Please write name so we can thank them!

Family/ Friend: _____ Other: _____

Patient Name: _____

DOB: _____

Reason for visit, current symptoms, and severity: _____ Date of Onset: _____

*** Please note 1 is mild pain and 10 is severe pain, circle one: ***

Headaches 1 2 3 4 5 6 7 8 9 10 Pins/Needles 1 2 3 4 5 6 7 8 9 10 1-6 Days
 Neck Pain 1 2 3 4 5 6 7 8 9 10 Numbness 1 2 3 4 5 6 7 8 9 10 Week(s)
 Mid Back Px 1 2 3 4 5 6 7 8 9 10 Radiating pain 1 2 3 4 5 6 7 8 9 10 Months
 Low Back Px 1 2 3 4 5 6 7 8 9 10 Ongoing

HEIGHT:

WEIGHT:

BP:(Staff Only)

Other: _____

Limitations:

Walking Bending Housework
 Dressing / Grooming Driving Getting in/out of bed
 Standing 30+ min Grocery shopping / Errands Climbing stairs / curbs
 Recreational Activity or sport Lifting / Carrying

Alleviating Factors:

Ice Heat Rest Activity Over the counter meds Prescribed meds

Prior Treatment:

Location

Location

Hospital _____ X-Ray/ CT Scan _____
 Urgent Care _____ MRI _____
 Primary Care _____ Pain Management _____
 Physical Therapy _____

Have you had Physical Therapy in the past 12 months? Yes: _____ No: _____

If yes, were you being treated for the same problem as today? Yes: _____ No: _____

HEALTH HISTORY

If no change in health since last visit, please check here: _____ **Women:** Any chance you are pregnant? Yes No

Medications: None List Here: _____

Allergies: None List Here: _____

Social History: Smoking? Yes No Alcohol? Yes No Exercise? Yes No
 1/2 Pack Daily Rarely
 1 Pack Weekly Occasionally
 1-2 Packs Socially Often

Medical History: No Medical History

Date	Illness/Diagnosis	Duration	Treatment

Date	Illness/Diagnosis	Duration	Treatment

Psychiatric History: None
 Anxiety Depression Bipolar OCD PTSD Other: _____

Family History: None Circle One

Diagnosis: _____ Living / Deceased Relationship: _____

Diagnosis: _____ Living / Deceased Relationship: _____

Surgical History: None

Date or Year	Surgery	Facility or Provider

Date or Year	Surgery	Facility or Provider

Date or Year	Surgery	Facility or Provider

Patient Name: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services.

For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initials: _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate. I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand it is my responsibility to obtain a referral from my PCP for specialty services if required from my insurance carrier. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage. You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Signature: _____

Date: _____

Verification of Claims Information

Motor Vehicle Accident / Worker Comp Only

Patient: _____ DOB: _____

For Motor Vehicle Accidents:

Auto Ins Company of Vehicle you were in: _____

For Work Comp Cases:

Name of Work Comp Ins Company: _____

Ins. Company Mailing Address: _____

City: _____ State: _____ Zip: _____

Ins. Company Telephone #: (_____) _____

Date of Injury / Accident: ____/____/____

Claim #: _____

Adjusters Name: _____ Tel#: _____

ATTORNEY INFORMATION

Name of Law Firm: _____

Attorney Name: _____

Telephone: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____