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

___ Other: _________________________________

HEIGHT:

WEIGHT:

BP:(Staff Only)

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

Smoking	Alcohol	Exercise
___ ½ 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:** ______________