

Physical Therapy & Sports Rehab, Inc.

Registration Form

Name _____		DOB _____		M _____ F _____	
Address _____		City _____		State _____ Zip Code _____	
Home # _____		Work # _____		Cell # _____	
Emergency Contact _____			Phone # _____		
E-Mail Address _____			Have you had physical therapy in the past 12 months? Y / N		
How did you hear about us? _____			Have you had Home Healthcare in the past 6 months? Y / N		
Discharge Date _____		Agency Name _____			
Employer _____		Phone # _____			
Address _____					

Primary Insurance _____		Subscriber _____		Subscriber DOB _____	
Subscriber Address _____		Relationship to Patient _____			
Secondary Insurance _____		Subscriber _____		Subscriber DOB _____	
Referring Physician _____			Phone # _____		
Primary Care Physician _____			Phone # _____		

Work related _____		Auto Related _____		Claim # _____		SS# _____	
Date of Injury/onset ___/___/___		Insurance Company _____		Adjuster _____			
Phone # ___-___-___		Insurance Company Address _____					
Is an Attorney involved in this case? Y / N Name _____ Phone # ___-___-___							

Are you currently taking any prescription or non-prescription medication (including anti-inflammatories, muscle relaxers, pain medications, etc.)? Y / N

List all _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema			Bowel or Bladder Problems		
Do you have a pacemaker?			Do you smoke? How much?		
High Blood Pressure			Severe or Frequent Headaches		
Heart Attack			Dizziness / Fainting		
Stroke/TIA/Blood Clot/Embolism			Vision or Hearing Difficulties		
Epilepsy/Seizures			Weakness If so, where?		
Neurological Disorders			Cancer/ Chemotherapy/ Radiation		
Thyroid Trouble/Goiter			Weight Loss / Energy Loss		
Infectious Disease			Varicose Veins		
Diabetes			Allergies		
Hernia			Any pins or metal implants?		
Arthritis/Swollen Joints			Joint Injury? If so, where?		
Osteoporosis / Gout			Are you Pregnant?		
Sleeping Problems/Difficulties			Emotional/ Psychological Problems		
Surgery			Chest Pain		

If you are unable to keep your appointment, please contact our office. A **\$25.00 late cancellation fee** will be charged if less than 8 hours notice is given. If you are 10-15 minutes late we may need to reschedule your appointment. Failure to keep an appointment will result in a **\$45.00 No Show charge** which will be your responsibility. **COPAYS are due on the day of treatment.** If you would like to pay for a series of visits, we request that payments be made at the beginning of the week. **Obtaining your referral** from your doctor is your responsibility. If you do not have the referral, **WE CANNOT SCHEDULE YOU AFTER THE 3RD VISIT.**

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. I authorize release of payment directly to Physical Therapy & Sports Rehab. I acknowledge that I have seen the "Notice of Privacy Practices."

Patient/Parent/Guardian Signature: _____

Date: _____

