

# Registration Form

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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 \_\_\_\_\_

**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 # \_\_\_\_-\_\_\_\_-\_\_\_\_  
**Please provide a copy of your auto insurance coverage selection page. Do you have Medical Payment coverage? Y / N**

List your current medications \_\_\_\_\_

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

	YES	NO		YES	NO
Asthma, Emphysema, COPD			Bowel or Bladder Problems		
Do you have a pacemaker?			Do you smoke? How much?		
High Blood Pressure/Chest Pains			Severe or Frequent Headaches		
Heart Attack			Dizziness / Fainting		
Stroke/TIA/Blood Clot/Embolism			Vision or Hearing Difficulties		
Epilepsy/Seizures/ Neuro. Disord.			Weakness If so, where?		
Thyroid Trouble/Goiter			Cancer/ Chemotherapy/ Radiation		
Infectious Disease			Surgery		
Diabetes			Allergies		
Arthritis/ Gout			Any pins or metal implants?		
Osteoporosis			Are you Pregnant?		
Sleeping Problems/Difficulties			Emotional/ Psychological Problems		

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 3<sup>RD</sup> VISIT. **Client's Initials:** \_\_\_\_\_

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."

Client/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_