

Accelerated Physical Therapy, Inc.

Patient Registration Form

First Name _____ MI ____ Last Name _____

Date of Birth _____ Social Security # _____ Gender

Mailing Address _____ Male Female

Physical Address _____

Driver's Lic # _____

Home Phone _____ OK To Call _____ Best Time To Call _____

Work Phone _____ _____

Cell Phone _____ _____

Marital Status Divorced Separated Married Single Unknown Widowed

Employment Status Active Military Full-Time None Part-Time Retired Self Employed

Student Status Full-Time None Part-Time

Email Address _____ Interpreter Required? Language _____

Patient Employer _____ Spouses Employer _____

Address _____ Address _____

Phone _____ Phone _____

Occupation _____ Occupation _____

How did you hear about us?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | |

Specify: _____

Signature of Patient _____

Date _____

Attorney Name _____

Phone _____

Address _____

Emergency Contact _____

Phone _____

Address _____

Prescribing MD _____

Phone _____

Do you have a written prescription? Yes No

Body Part / Region _____

Date of Injury _____

Was this injury the result of an accident? Work Auto Other None

Do you wish to receive social services? Yes No

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Accelerated Physical Therapy. Further, I authorize Accelerated Physical Therapy to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by Accelerated Physical Therapy, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been shown the posted Notice of Information Practices by Accelerated Physical Therapy.

AUTHORIZATION FOR PAYMENT OF SERVICES

I hereby consent to be treated by Accelerated Physical Therapy, Inc. I agree to furnish proof if another party is responsible for payment. I request any payments of authorized insurance benefits for me or on my behalf be paid directly to Accelerated Physical Therapy, Inc. I authorize Accelerated Physical Therapy, Inc. to file my insurance with the insurance company named below. I authorize the release of any medical information to Accelerated Physical Therapy, Inc. to process this and any future claims. I understand that I am responsible for all reasonable charges incurred if this amount is turned over to an attorney for collection. I also understand that any appointment missed or canceled less than 24 hours from scheduled appointment time may be assessed a cancellation fee. A portion of charges not covered by insurance will be due at time of service. I have received the NOTICE OF PRIVACY PRACTICES form.

Signature of Patient

Date

MEDICAL HISTORY FORM

Area of Symptoms: _____ Age: _____

Date of Onset: _____

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you.

Any known results of recent x-rays or tests: _____

Chronic Conditions: Yes No If yes, please list: _____

Allergies: Yes No If yes, please list: _____

List surgeries and dates: _____

Medications: Yes No If yes, please list: _____

Do you have or have you had any of the following:

Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Metal Implants	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy or Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

1. How would you rate your ability to perform routine daily activities:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Unable to perform _____ No Problems

2. How would you rate your ability to perform the activities associated with your job:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Unable to perform _____ No Problems

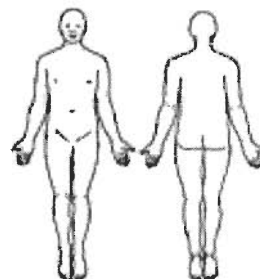
3. How would you rate your current pain:

0 1 2 3 4 5 6 7 8 9 10
None _____ Emergency Room

4. How many days since your current injury? 0-30 days 31-90 days 90+ days

Please draw your pain on the body to the right using the following symbols:

/// Stabbing pain
xxx Burning
ooo Pins and needles
=== Numbness



Are you currently or have you received physical therapy or home health care this year? Yes No

Patient Signature _____ Date _____