

**Patient Registration**

**Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_M \_\_\_\_\_F Social Security # \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_ Current Height \_\_\_\_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_\_\_\_**

**Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_**

**Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: \_\_\_\_\_Single \_\_\_\_\_Married**

**Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Health Insurance, Policy Holder's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**Secondary Insurance (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder name & DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ~Are you working now? \_\_\_\_\_\_ YES \_\_\_\_\_NO**
* **Are your injuries related to a Motor Vehicle Accident Claim? \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **In what City & State did the accident occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Did you take any photos of the accident (if so, please provide copies)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **What was the extent of damage to your vehicle (i.e. is it drivable or did it need to be towed from the accident scene)?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Was the other party cited by the authorities, if so, what agency responded to the scene? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Do you have of a copy of the police report? If so, what is the police report # ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8. Do you have an attorney currently representing you, if so, please provide the name and contact info.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Approximate date of injury? \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Is it getting worse, better, or staying the same? \_\_\_\_\_\_\_\_**

**10. Where is your pain/problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**11. What caused your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had this pain before? \_\_\_\_\_\_YES \_\_\_\_\_\_NO**

**12. Is your pain constant? (never goes away) \_\_\_\_\_YES \_\_\_\_\_NO**

**13. Are any of your usual daily activities affected? \_\_\_\_YES \_\_\_\_NO**

**~If yes, describe how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**14. On the scale, circle your worst pain level in the past couple of days:**  Mild Moderate Severe

1....2…3…4.….5….6….7....8....9….10

**14. Are you taking any medication for this pain/problem? \_\_\_\_YES \_\_\_\_NO**

 **~If yes, what are you taking and does it help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**15. List all medications you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16. List all past surgeries with dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**17. List all medical conditions you have (or were told you have)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent to Treatment:** I consent to rehabilitation and related services at Advanced Physical Therapy. I understand, acknowledge and affirm that such rehabilitation and related service may involve bodily contact, touching, and/or direct contact of a sensitive nature. \_\_\_\_\_\_\_\_\_\_\_ **initial**

**Liability:** I know and agree that Advanced Physical Therapy is not responsible for loss or damage to personal valuables. \_\_\_\_\_\_\_\_\_\_\_ **initial**

**Patient Agreement: I hereby authorize Advanced Physical Therapy to communicate with, and furnish, my attorney, a full report of his/her examinations, diagnosis, treatment, and prognosis of my injuries, arising from the accident in which I was involved, if requested, and copies of my medical records. I further authorize and irrevocably direct to Advanced Physical Therapy such billings and/or fees that may be owed to Advanced Physical Therapy for services/treatment by reason or related to the above-described accident. I fully realize and understand that I am directly and fully, personally responsible to Advanced Physical Therapy for all physical therapy billing and that this obligation is not contingent upon my receiving any settlement or award for my claim.**

**Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Office Policies**

Because we commonly have a waiting list, **we have a $25 charge for missed appointment or for cancellation with less than 24 hours notice.** Additionally, if you are going to be more than 15 minutes late, please provide us with a courtesy call as this will hold your appointment and you will not incur a charge for missed appointment. Please help us serve you better by keeping your scheduled appointments so we can better serve you in a timely, professional manner.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Agreement**

 *Regarding Insurance:*

As a service to you, our billing office will gladly bill your insurance company directly on a bi-weekly basis. Our billing office will also bill supplemental insurance and secondary insurance companies. For us to perform this service for you, please provide us with the necessary information specified below:

* If you are using health insurance, we will need to obtain a copy of your insurance card, as well as the assignment of benefits form filled out (located in new patient paperwork). **Each patient is responsible for meeting their deductible and paying co-insurance/co-payments according to their insurance plan at the time of service.**
* If you have no insurance coverage, or if we are unable to verify medical benefits, we offer a discounted cash option at the discretion of the provider. Payment is due in full at the time of service.
* **To better serve you, we request a credit card to be on file with our office. This card can be used for co-pays and/or co-insurance amounts, secure your appointment date & time, or can be used as a backup should you forget to bring your method of payment on your treatment date.** This option allows us to take care of any charges for you without having to reschedule your appointment.

\*\*PLEASE SIGN ON THE LINE BELOW THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE**,** REGARDLESS OF WHETHER YOU CHOOSE TO HAVE A CREDIT CARD ON FILE.

**Card #**

**Exp Date \_\_\_\_\_\_\_\_\_\_ CVV\_\_\_\_\_\_\_\_\_\_**

 **Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

