Physical Therapy Registration & History

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City Sate Zip

Sex: □M □F Age_____

DOB____/___/_____

□Single □ Married □ Widowed
□Divorced □ Separated

SSN#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Spouse SSN#_____DOB_____

Occupation_____

Employer_____

Whom may we thank for referring you?

_____

INSURANCE

Who is responsible for this account? _____

_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Add'l insurance coverage? Yes No

Subscriber's Name

_____

DOB_____SSN#_____

Relation to Patient_____

Insurance Co._____

Group#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependents) have insurance coverage with_____and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission.

_____

Responsible Party Signature

_____

Relationship Date

PHONE NUMBERS

Home_____**Work**_____

Mobile_____**Email**_____

Best time & place_____

IN CASE OF EMERGENCY CONTACT:

Name_____

Home /Mobile_____

Work_____

ACCIDENT INFORMATION

Is condition due to an accident? □ Y □N

Date of Accident_____

Type of Accident:

□Auto □Work □ Home □Other

To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Worker Comp □ Other_____

Attorney Name (if applicable)

_____

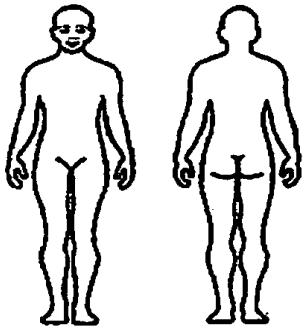
PATIENT CONDITION

Reason for visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse?___Yes___No___Maybe

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate your pain on a scale of 1 (least pain) to (10 severe pain)_____.

Type of pain: □ Sharp □ Dull □Throbbing □Numbness □Aching □Shooting □ Burning □Tingling □Cramps □Stiffness □Swelling □Other

How often do you have the pain?_____

Is it constant or does it come and go?_____

Does it interfere with: □ Work □Sleep □Daily Routine □Recreation

Activities or movements painful to you: □ Sitting □Standing □Walking □ Bending □Lying down

HEALTH HISTORY

What treatment have you received for your condition?

□Medication □Surgery □Physical Therapy □ Chiropractic □ None □Other

Name and address of other doctor(s) who have treated you for your condition:_____

Date of Last: Physical Exam_____Spinal X-Ray_____Blood Test_____

Spinal X-Ray_____Chest X-Ray_____Urine Test_____

Dental X-Ray_____MRI, CT-Scan, Bone Scan_____

Please check to indicate if you have had any of the following:

☐ AIDS/ HIV	☐ Goiter	☐ Pneumonia
☐ Alcoholism	☐ Gonorrhea	☐ Polio
☐ Allergy Shots	☐ Gout	☐ Prostate Issues
☐ Anemia	☐ Heart Disease	☐ Prosthesis
☐ Anorexia	☐ Hepatitis	☐ Psychiatric Care
☐ Appendicitis	☐ Hernia	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Herniated Disk	☐ Rheumatic Fever
☐ Asthma	☐ Herpes	☐ Scarlet Fever
☐ Bleeding Disorders	☐ High Cholesterol	☐ Stroke
☐ Breast Lump	☐ Kidney Disease	☐ Suicide Attempt
☐ Bronchitis	☐ Liver Disease	☐ Thyroid Issues
☐ Bulimia	☐ Measles	☐ Tonsillitis
☐ Cancer	☐ Migraines	☐ Tuberculosis
☐ Cataracts	☐ Miscarriages	☐ Tumors/Growths
☐ Chemical Dependency	☐ Mononucleosis	☐ Typhoid Fever
☐ Chicken Pox	☐ Multiple Sclerosis	☐ Vaginal Infections
☐ Diabetes	☐ Mumps	☐ Venereal Disease
☐ Emphysema	☐ Osteoporosis	☐ Whooping Cough
☐ Epilepsy	☐ Pacemaker	Other_____
☐ Fractures	☐ Parkinson's	
☐ Glaucoma	☐ Pinched Nerve	

HEALTH HISTORY (continued)

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day_____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

INJURY/SURGERY HISTORY

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharm. Phone_____		

Oceanside Physical Therapy, Inc.

Bryan Graham, MPT

2030 SE Ocean Blvd.

Stuart, Florida 34996

PH-772.283.3820 FAX-772.283.3825

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and/or reviewed the Notice of Privacy Practices for Oceanside Physical Therapy, Inc. I further acknowledge that I have been encouraged to read the entire notice as it provides information about how my protected health information may be used and disclosed.

The Notice of Privacy Practices is subject to change.

I understand that this acknowledgement form will be placed in my patient chart and shall remain there for 6 years.

Name of Patient_____
(Print)

Signature of Patient or Legal Representative: _____

Date:_____

If not signed by patient, please indicate relationship:

_____Parent or guardian of a minor _____Guardian

_____Other representative

Please note: Refusing to sign this document will not impact your ability to receive physical therapy services.

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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*Signed*_____ _____ *Date*_____

Oceanside Physical Therapy, Inc.
2030 SE Ocean Blvd.
Stuart, Florida 34996
772.283.3820

Late Cancellation and Non-Attendance Policy

We respect your time, and ask that you respect ours. Oceanside Physical Therapy does have a 24 hour cancellation policy. We do ask that you notify our office if there is any reason you cannot attend and we will gladly re-schedule your appointment.

If you do not show, or give less than 24 hours notice, you will be subject to a $50 fee per visit missed, which will be billed to you directly. This fee will not be covered by your insurance policy.

Thank you.

Patient Signature_____ Date_____

Staff Signature_____ Date_____

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Release of Patient Records Authorization

I hereby authorize Oceanside Physical Therapy, Inc. to release copy of my patient records or x-rays containing protected health information to:

	Please Circle
My Doctor(s)	Yes or No
Insurance Companies	Yes or No
My Attorney	Yes or No
Other_____	Yes or No
Other_____	Yes or No

Specific description of information to be disclosed:

_____

_____

_____

This authorization is provided pursuant to Florida Statutes (F.S.) section 465.057 and regulations pursuant to the Health Insurance Portability and Accountability Act (HIPAA). I understand that F.S. 456.057(1) makes it clear that my third party to whom records are disclosed is prohibited from further disclosure of any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

Name of Patient:_____(Clearly Print)

Date of Birth: ____/_____/_____

Signature of Patient or Legal Representative:_____

Date:_____

If not signed by patient, please indicate relationship:

_____Parent or guardian of a minor _____Guardian

_____Other representative