

# Physical Therapy Registration & History

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ 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) \_\_\_\_\_.

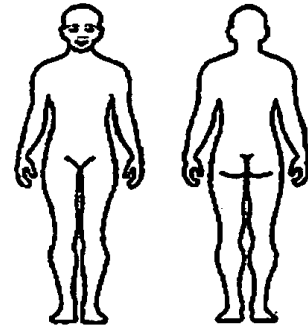
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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:

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

**HEALTH HISTORY (continued)**

**EXERCISE**

\_\_\_ None  
\_\_\_ Moderate  
\_\_\_ Daily  
\_\_\_ Heavy

**WORK ACTIVITY**

\_\_\_ Sitting  
\_\_\_ Standing  
\_\_\_ Light Labor  
\_\_\_ Heavy Labor

**HABITS**

\_\_\_ Smoking  
\_\_\_ Alcohol  
\_\_\_ Coffee/Caffeine  
\_\_\_ High Stress Level

Packs/Day \_\_\_\_\_  
Drinks/Week \_\_\_\_\_  
Cups/Day \_\_\_\_\_  
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.

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***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:

	<u>Please Circle</u>
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:

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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