Oceanside Physical Therapy, Inc. - Registration & History

Patient Information: Date: _____

Name: _____ Age: _____ Date of Birth: ___/___/____

Home Ph#: _____ Cell Ph#:_____ S M W D

Home Address: _____

Email Address: _____ Employed Retired Student Child

Emergency Contact: _____ Ph#: _____ Relationship: _____

Employer: _____ Employer Phone: _____

Attorney Name: _____ Ph#: _____

Whom may we thank for referring you? _____ SS#_____

Insurance Information: Medical Auto Accident Workers Comp.
Primary Insurance: _____ Policy#:_____

Primary Insured Name: _____ D.O.B. _____

Secondary Insurance: _____ Policy#:_____

Assignment and Release **Patient is Selfpay** **Patient has Insurance**

I certify that I, or my dependent has insurance or is selfpay and assign payment to go directly to **Oceanside Physical Therapy** for any and all Insurance that I have now or in the future while I am a patient here. I further release any records to the discretion of **Oceanside Physical Therapy** so that they may get my claims paid. Records may be released to my medical insurance, doctors, medical facilities, attorneys, auto ins., etc.. as necessary. **I understand that I am responsible for payment whether or not I have insurance.** This includes deductibles, copays, co-insurance and any denied charges.

Responsible Party Signature: _____ **Date:** _____

Relationship to patient: Self Parent Guardian Other: _____

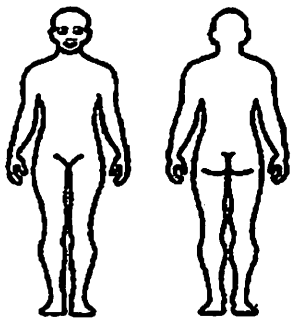
PATIENT CONDITION

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

Other_____

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_____

Height_____ **Weight**_____

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:

_____

_____

_____

*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