SPORTS & PHYSICAL THERAPY CENTER Rehab1Network

REGISTRATION FORM

(Please Print)

Today's date: ❑ Returning Patient		❑ New Patient
Referring Physician:	Phone ( )	Date Last Seen:
Primary Care Physician:	Phone ( )	Date Last Seen:

PATIENT INFORMATION

Patient's Last name: First: Middle:				Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Birth date: / /	Age:	Sex: ❑ M ❑ F
Email address:				
Street address:		Social Security # :		
City:	State:	ZIP Code:		
Occupation:	Employer:		Employment status:	

Please check one box for each phone number:	It's ok to leave a detailed message	Leave only a call back number
Cell Phone:	☐	☐
Home Phone:	☐	☐
Work Phone:	☐	☐

How would you like to be contacted: Cell Home Work

Emergency Contact:	Phone Number:
❑ It's ok to leave a detailed message	❑ Leave only a call back number

INJURY INFORMATION

Body Part Injured:	Post-Surgical: ❑ Yes ❑ No	Date of Surgery:

Do you have an appointment to return to your referring physician?

How did this injury occur:

Have you received ANY previous physical, speech, occupational therapy or chiropractic services since January 1st of this year from ANY provider (hospital, nursing home, home health, other outpatient facility)?

❑ Yes ❑ No If yes, from whom: How many visits did you have? When was your last visit:

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REFERRAL INFORMATION

Chose clinic because/Referred to clinic by (please check one box):

❑ Doctor ❑ Newsletter ❑ Insurance Plan

❑ Current Newsmagazine ❑ Post Card ❑ Close to home/work ❑ Yellow Pages ❑ Internet Database ❑ Advertising

❑ Family ❑ Friend ❑ Screening ❑ Other:

Name of family/friend members seen here:

Release of Medical Information

I hereby give my consent for Sports and Physical Therapy Center, Rehab 1 Network and/or its affiliated office to release information regarding my treatment and/or billing to the following:

_____ _____

Print Person's Name Relationship

_____ _____

Print Person's Name Relationship

❑ I give permission to release information regarding my treatment to another physician: Dr. _____

❑ Do NOT give out any information, even to family, unless specifically authorized to do so.

Notice of Privacy Practices

I have been given a copy of the Sports and Physical Therapy Centers Privacy Practices:

_____ _____

Patient/Parent/Legal Guardian Signature Date

Consent to Treat and Insurance Release Information

I hereby consent to the medical care and treatment procedures as determined necessary by my physician(s). I further authorize Rehab1Network and/or its affiliated office(s) to release to my insurance company any necessary information needed to file and expedite payment on my claim. I hereby irrevocably assign and transfer to this facility any and all benefits, either contractual, common law, or statutory, to which I am entitled or which are available to me under any medical, health, and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to this facility. I further authorize and agree that a copy of this authorization shall be deemed valid as the original. In the event that I would fail to pay my bill, I agree to pay any additional charges related to the cost of collection (including, but not limited to, collection agency fees, reasonable attorney fees and court costs). In the case of a returned check, there will be an additional $30.00 charge. In consideration of our other patients, I understand, if possible, I will contact this facility in advance if I need to cancel or arrive late for an appointment. I understand if I fail to show for an appointment without notification, I may be charged a $30.00 Missed Appointment fee for each missed visit. If I miss two (2) or more consecutive appointments without notification, all future appointments may also be cancelled. I further understand if circumstances result in my late arrival for a scheduled appointment, I may be asked to re-schedule. If I cancel two or more appointments without a 24-hour notice, I may also be subjected to the $30.00 Cancelled Appointment charge for each cancelled appointment. Missed and/or Cancelled Appointment charges are my responsibility and will not be billed to my insurance provider.

I acknowledge the information on this form to be accurate.

X_____ _____

Patient/Parent/Legal Guardian Signature Date

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MEDICAL HISTORY

Have you ever been told you have… (check all that apply)

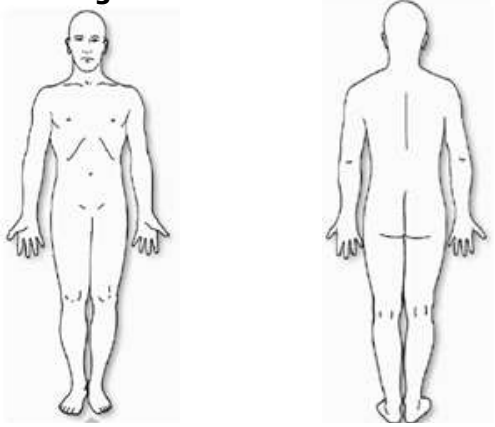
- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or Emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart Attack (myocardial infraction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
  List:

- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis / Aids
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer
- ☐ Prior Surgery:
  Explain:

Have you ever tested positive for:
Hepatitis: ❑ Yes ❑ No
Tuberculosis: ❑ Yes ❑ No
HIV: ❑ Yes ❑ No

Do you or have you in the past smoked tobacco?
❑ Yes ❑ No

Please indicate on the drawing below where you are having pain and what type of pain you are having.



Describe Your Pain	
Is your Pain:	
Numbness	
Burning	
Pins and Needles	
Sharp	
Dull and Aching	
Weakness	

How long have you had this pain? _____

What makes the pain better? _____

What makes the pain worse?_____

Does your pain change with:
Exertion ❑ Yes ❑ No
Stress ❑ Yes ❑ No
Activity ❑ Yes ❑ No

As of right this minute, are you
❑ better ❑ the same ❑ worse
than when you saw your referring physician last?

Are you ❑ working regular duty?
❑ working with restrictions?
❑ not currently working?

What are your goals for therapy?

X_____
Patient or Guardian Signature Date