FIRST CHOICE Physical Therapy

Today's Date_____

Patient Registration

Patient Name: _____ _____

First MI Last Preferred Name

_____ _____ _____

Social Security Number Date of Birth Email Address

_____

Street Address City State Zip Code

Home #: _____ Cell #: _____ Work #: _____

Marital Status: Married Single Divorced Widowed Sex: Male Female

Reason for your visit:

Injured/Painful Body Part: _____ Affected Side: Right Left Bilateral

Date Problem Began or Injury Occurred: _____

Emergency Contact: _____

Name Relation Phone Number

Guardian Information: (If Patient is a Minor):

_____ _____ _____

First M Last Relation to Patient Social Security Number

_____ _____ Sex: Male Female

Date of Birth Contact Phone Number

Referring/Primary Care Doctor: _____ Phone Number: _____

Please Complete all that apply:

Sport: _____ Position: _____ Level: _____

Team: _____ Coach's Name: _____ Trainer's Name: _____

Student/School: _____ Year/Grade: _____ Occupation: _____

ONLY FILL OUT THIS SECTION IF YOU WERE INJURED IN AN AUTO ACCIDENT:

Did this injury occur as a result of a motor vehicle accident: YesNo

Have you had emergency treatment for this injury: Yes No

Do you have an attorney: YesNo

ONLY FILL OUT THIS SECTION IF THIS INJURY IS RELATED TO AN ON THE JOB ACCIDENT:

Did this injury occur while you were working: Yes No

Name of Employer: _____ Date of Injury: _____

Your Position_____

Are you currently working: Full Duty Light Duty Off Work

FIRST CHOICE Physical Therapy

Confidentiality Statement

Patient Name: _____ Date: _____

Payment Information:

Form of Payment: (circle) Health Insurance Auto Insurance Worker's Compensation Self Pay

Primary Insurance

Insurance Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured DOB: _____

Secondary Insurance

Insurance Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured DOB: _____

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Notice of Privacy Policy: I am aware that First Choice Physical Therapy has a "Notice of Privacy Policy Practices". I understand that a copy is available to me and I agree with these privacy policies.

Release of Information: I authorize First Choice Physical Therapy to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.

Payment Agreement: I agree to pay for medical services rendered at First Choice Physical Therapy and should my insurance deny payment, I am responsible for the entirety of my bill. I understand that any co-payments or deductibles are due at each visit when I check out. I further understand it is my responsibility to insure that First Choice is in network with my insurance and that any and all pre-certifications/authorizations have been approved.

No Show Agreement: There will be a $20.00 No Show fee if not rescheduled/cancelled within 24 hours of appt time.

Social Media: HIPPA prohibits any posting on social media in this clinic without prior written authorization.

I authorize First Choice Physical Therapy to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick medical records/forms ect. on my behalf. These individuals will be considered emergency contacts.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as a parent or child of a patient over 18 years of age.

I authorize First Choice Physical Therapy and staff to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I acknowledge that I have reviewed the above information.

_____ _____

Patient Signature Date

FIRST CHOICE Physical Therapy

Medical History Form

Patient Name: _____ Date: _____

Height: _____ **Weight:** _____

Reason for visit: _____ Date of Onset: _____

Medical History:

Check if you have had any of these medical problems in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type_____			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis - TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			Other _____		

Please list any **operations/surgeries** you have had:

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **medications** that you are currently taking:

MEDICATION	DOSE	MEDICATION	DOSE
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Do you have any **allergies** to medications/substances? YES NO

Social History:

Alcohol use: YES NO Drinks per week: _____

Cigarette use: YES NO Packs per day: _____ Years: _____

Smokeless Tobacco use: YES NO Years: _____

Illicit Drug use: YES NO Type: _____

Review of System: Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing			Depression		
Fever/Chills			OTHER:		

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_____ _____

Patient Signature Date