Date: _______________

PATIENT REGISTRATION

First Name:
Middle Name:
Last Name:
Nickname (Alias):
Gender:
Date of Birth (MM DD YYYY):
Marital Status: (circle) Single Married Divorced Widowed
How did you hear about us?

HOME ADDRESS

Address 1:
Address 2:
City:
State/Province:
Zip Code:

CONTACT

Email Address:
Home Phone:
Mobile Phone:
Preferred Contact Method: (circle) Home Mobile E-mail

SOCIAL SECURITY

Social Security Number:

EMERGENCY CONTACT

Relationship:
Contact Name:
Contact Phone:

FAMILY DOCTOR and or REFFERING DOCTOR

Name:

EMPLOYER INFORMATION

Employer Name:

IF PATIENT IS UNDER 18 WHO US RESOPONSIBLE FOR BILLABLE SERVICES

Name:	
Relationship to Patient:	Phone # (if different from above):

IF RETURNING PATIENT PLEASE CONFIRM INFORMATION IF NEED BE UPDATED. DATE/INITIAL: _________________

MEDICAL HISTORY FORM Date: _____________

Patients Name:	Date of Birth:
ALLERGIES: Please list any medication(s) you are allergic to:	
Are you latex sensitive? (circle) YES or NO	
List any other allergies we should know about?	
Have you declared the Advanced Directive of Do Not Resuscitate? (circle) YES or NO	
Please X all the following that apply:	

	Alzheimer's		Kidney Disease		Obesity
	Cardio Vascular Disease		Chemical Dependency (ie alcoholism)		Osteoarthritis
	Cauda Equina Syndrome		Multiple Sclerosis		Parkinson's
	Cerebral Vascular Accident		Epilepsy		Rheumatoid Arthritis
	Current Infection		Depression		Traumatic Brain Injury
	Diabetes Mellitus		HIV		High Blood Pressure
	Emphysema/COPD/Asthma		History of Cancer		Immunosuppression
	Fibromyalgia		Huntington's		Lupus
	Fracture or Suspected Fracture		Hepatitis		Muscular Dystrophy
	Other	For Woman: Are you currently pregnant or think you might be? YES or NO			

Please list any surgeries, injuries or other conditions

Date:	Surgery, Injury, Condition	Date:	Surgery, Injury, Condition

Please X the box for the following OVER-THE-COUNTER medications you have taken in the last week

	Advil/Motrin/Ibuprofen		Asprin		Tylenol		Antacid		Laxatives
	Vitamins/Mineral Supplements		Decongestants		Antihistamine		Other:		

Please write medications you are currently you are taking (INCLUDING pills, injections, and/or skin patches): If you carry a list, we can make a copy

____

____

Have you recently noted any of the following? (Please X the appropriate box)

	Weight loss/gain		Numbness/Tingling		Fatigue
	Nausea/Vomiting		Fever/Chills/Night Sweats		Weakness

Height:	Weight:

IF RETURNING PATIENT PLEASE CONFIRM INFORMATION IF NEED BE UPDATED. DATE/INITIAL: _______________

MEDICAL HISTORY FORM Date: _____________

Patients Name:	Date of Birth:
Surgery: YES or NO	Date of surgery:
Procedure Performed:	

DIAGNOSTIC TESTING

	No Diagnostic Tests		Ultrasound		X-RAY
	Arthroscopy		EMG/Nerve Condition		MRI

CHECK ALL THAT APPLY…I HAVE PAIN OR DIFFICULTY

	Walking		Getting up from a chair		Driving
	Bending at the waist		Standing		Lifting
	Sleeping				

HAVE YOU EVER HAD THIS PROBLEM(S) BEFORE? YES OR NO

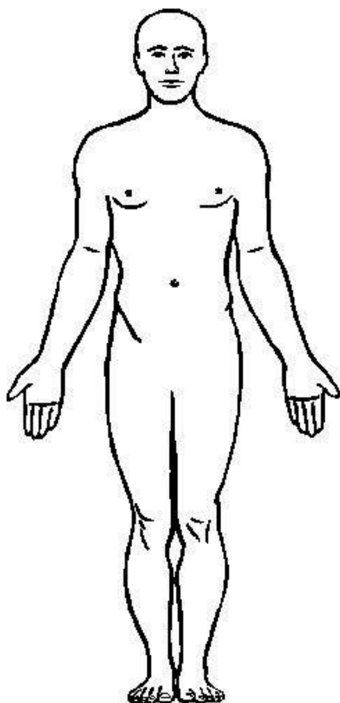
Have you ever had this problem treated?
How long has this problem been going on?
Did this problem get better? **YES OR NO**

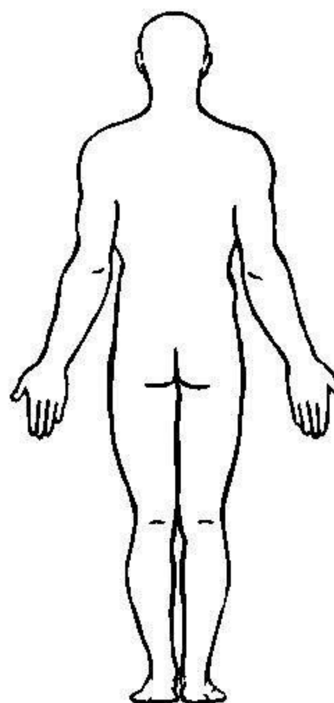
PLEASE INDICATE THE PAINFUL AREAS ON THE DRAWING

X – Constant Pain, O - Intermittent

RATE YOUR PAIN 0 – 10 (0 = No Pain, 10 = Unbearable Pain)

CURRENT_____BEST____WORST_____





We are very glad that you are choosing South Mountain Physical Therapy for your physical therapy needs. So that you can be informed about our policies and services, we ask that you take note of the following:

- Please notify our staff of any changes in address, phone number or insurance coverage as soon as changes are made.
- If you have a co-pay, your insurance company mandates your co-payment is due at the time your visit.
- Please know that our communicating with your insurance company regarding your claims is a courtesy to you. You are fully responsible for knowing your insurance coverage and maintain that knowledge as an advocate for yourself. If your insurance coverage terminates coverage or expires, you are fully responsible for changes incurred.
- Depending on your insurance coverage, you, the customer, may be monetarily responsible for a portion of your care (i.e., co-pay, co-insurance, or deductible). If your account goes into delinquency, there may be additional costs accrued, Including: collection fees, court costs, attorney fees, and administration fees, up to 30% of your outstanding bill.
- South Mountain PT is not contracted to work with Medicaid (Access) Insurance. If you have this insurance, you may still choose to receive treatment at the facility. However, by signing this form, you are acknowledged that we are not contracted with Medicaid, and you will be responsible for any outstanding payment for services, which is covered by your insurance.
- Discrimination against consumers is prohibited because of race, color, religious creed, ancestry, national origin, age, sex, or disability.

I ____________________________ (signature) have read and understand the terms of being a physical therapy patient at South Mountain Physical Therapy, LLC. ____________ (date)

Assignment of Insurance Benefits

- The undersigned authorizes payment of medical benefits to the therapists practicing under this location or any location for any services to me by these therapists. I understand I am financially responsible for any amount not covered by any insurance contract listed above. I agree to pay all those charges for those services and I am aware if I do not pay the balance of my account within a responsible time, my account will be forwarded to a collection agency. My signature that insurance payment may be made directly to the clinician and/or facility location providing service to me. _________ (initials)
- I authorize the release of any medical records or health care, advice, treatment of supplies provided to _________ (initials). This information will be used for the purpose of evaluating and administering claim benefits. _________ (initials)
- I permit a copy of this authorization to be used in a place of the original.

Signature: ____ Date: ____________________

Confidentiality/Privacy Policy

The medical care we provide our patients is confidential. South Mountain PT will protect the confidentiality of your medical information in verbal, written, and electronic form in accordance with Section 164.520 of the Code of Federal Regulations. We will not release information to anyone, without signed consent, unless they meet legal expectation requirement.
I have received and understood the confidentiality policy. I wish to have the following restrictions or permissions to the use or disclosure of my health information: __________________________________

Signature: ____ Date: ______________________