Patient Registration Form

Name_____Nickname_____DOB_____/_____/_____

Address_____City_____Zip_____

Home Phone #_____ Work #_____ Cell #_____

May we leave a message at the number(s) above? _____

E-mail _____ Can we add you to our e-mailing list? _____

Emergency Contact _____ Relationship _____ Phone #_____

Referring MD_____ Primary MD_____

Reason for Referral_____ Next Follow Up Appointment: _____

Primary Insurance Information – Please Print Clearly

Primary Insurance_____Subscriber ID_____

Subscriber's Name_____Subscriber's DOB_____/_____/_____

Relation to Patient_____ Person Responsible for Billing_____

If your benefits require a prior authorization or referral it is your responsibility to inform us*

HIPAA Authorization/Privacy Policy Acknowledgement and Disclosure

I, _____, hereby authorize Procare Physical Therapy to use and disclose my Protected Health Information for payment, treatment, health care operations and for such other purposes that are permitted under HIPAA Law. Procare Physical therapy is permitted to leave test result and any other health related information on my voicemail. I also authorize the following individuals to receive patient information on my behalf:

1. Name_____Relationship:_____Phone:_____

2, Name_____Relationship:_____Phone:_____

3. Name_____Relationship:_____Phone:_____

I understand that Procare Physical therapy has privacy policies in place. I acknowledge the receipt of Procare Physical therapy's Privacy Notice, bearing an effective date of May 2, 2011.

How did you learn about Procare Physical Therapy? Please check all that apply.

My doctor specifically recommended Procare

Listed on my Insurance Website / Provider Directory

I chose Procare from a list my MD provided

On-line search led me to Procare

Family member, friend, or co-worker recommended Procare / Name: _____

Social Media: Facebook Twitter (Please circle one)

other: _____

Medical History Form

Procare™ PHYSICAL THERAPY

Have you had or do you have any of the following? (Please check if yes)

___Asthma ___ Anemia ___ Aneurysm ___ Heart Attack/Disease* ___ Angina/Chest Pain ___ Diabetes

___ High Cholesterol ___ Epilepsy ___ Abnormal EKG ___ High Blood Pressure* ___ Stroke

___ Pacemaker ___Varicose Veins ___ Irregular Heart Beat ___ Fibromyalgia ___ Other: _____

___ Cancer / If yes, what type: _____

Do you have any of the following that may limit your exercise?

_____ Arthritis _____ Hip/Pelvis Injury _____ Shoulder Injury _____ Bone Fracture _____ Knee Injury

_____ Ankle/Foot _____ Back Injury _____ Wrist/Hand Injury____ Nerve Damage _____ Head/Neck

Details: _____

Do you have any allergies? _____

Has your physician ever advised you against exercise? ( ) YES ( ) NO

Physicians Name: _____ Phone#:_____ Last Exam: _____

Are you currently receiving Physical Therapy? ( ) YES ( ) NO / if yes, where: _____

Are you currently being seen by any other doctors/chiropractor? ( ) YES ( ) NO / Who: _____

Have you ever received physical therapy in the past for this or any other condition? ( ) YES ( ) NO

List: _____

Surgical History ( ) YES ( ) NO Date(s) Type(s)

_____

_____

Are you presently taking any medications? ( ) YES ( ) NO
If yes, please list names and dosages:

_____

_____

Are you currently involved in an exercise program? ( ) YES ( ) NO
Describe:

_____

Any other medical concerns not previously mentioned?

_____

_____

Client / Parent Signature: _____ Date: _____
(under 18)