Athletic Edge
PHYSICAL THERAPY

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Patient Registration

(Please write legibly)

Today's Date:	Date of appointment:	Reason for treatment:	☐ Self-Pay ☐ Insurance ☐ Auto ☐ Work Comp
First Name, Middle Initial:		Last Name:	
Date of Birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced	Minor: ☐ Yes ☐ No
Street Address:		City:	State: / Zip:
Home Phone:	Cell Phone:	Work Phone:	Email:
Please Remind me of appointments via: ☐ Phone ☐ Email	Emergency Contact:	Phone #:	Relation:
Employer:			Occupation:
Employer Address:		City:	State: / Zip:
Primary Care Physician (*first, last*):	Phone #:	Location:	Have you had PT before? ☐ Yes ☐ No
Referring Physician (*first, last*):	Phone #:	Location:	When?
Primary Health Insurance:	Member #:		Group #:
Insured's Name:		Insured Date of Birth:	Relation:
Secondary Health Insurance:	Member #:		Group #:
Insured's Name:		Insured Date of Birth:	Relation:
Are you currently, or have you recently received Home Health services? ☐ Yes ☐ No		If yes are you still receiving treatment? ☐ Yes ☐ No	
		If no, when were you discharged?	
Auto/Accident/Worker Comp Insurance:		Claim#:	Date of Injury:
Adjuster Name:		Phone #:	Fax#:
Attorney Name:		Phone:	Fax#:
May we send you our newsletter? ☐ Yes ☐ No	How did you hear about us?		

Health Status Form

Date: | Patient Name:

Present Complaint: | Date of Onset:

How did injury occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other _____

Do you have pain? ☐ Yes ☐ No | Rate Pain (0 no Pain – 10 high pain) At Best: _____ At Worst: _____

Have you had physical therapy for this problem before? ☐ Yes ☐ No | If yes, when:

What tests have been done for this condition? (check all that apply)

☐ CT Scan ☐ MRI ☐ X Ray ☐ EMG ☐ Bone Scan ☐ Ultrasound ☐ None ☐ Other _____

Describe your overall general health : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History

If yes, please provide details

High Cholesterol	☐ Yes	☐ No	_____	Stroke	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____	Blood Clots	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____	Pacemaker	☐ Yes	☐ No	_____
Seizures/Neurological	☐ Yes	☐ No	_____	Cancer/Tumor	☐ Yes	☐ No	_____
Behavioral/Learning	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Anxiety/Depression	☐ Yes	☐ No	_____	Hepatitis/HIV	☐ Yes	☐ No	_____
Genetic/Congenital	☐ Yes	☐ No	_____	Asthma/COPD	☐ Yes	☐ No	_____
Are you pregnant?	☐ Yes	☐ No	_____	Do You Smoke?	☐ Yes	☐ No	_____
Bone Joint Problems	☐ Yes	☐ No	_____	If so, how much:			_____

Other (describe): _____

Significant Past Surgeries: _____

Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: _____

_____

_____

List all food and medical allergies (include latex & adhesives): _____

_____

_____

Daily Activities

What does your job and/or home duties require? Check all that apply:

☐ Computer Work	☐ Standing	☐ Reaching	☐ Carrying
☐ Kneeling/Squatting	☐ Walking	☐ Climbing	☐ Lifting
☐ Repetitive Movement/Twisting	☐ Writing	☐ Pushing/Pulling	☐ Other _____

_____ _____

Signature of Patient or Legally Authorized Representative | Date

Consent to Treatment

I hereby authorize the profession staff at **Athletic Edge Physical Therapy** to examine and treat me with physical therapy for the Injury I have been referred here for or referred myself to.

_____ _____
Patient Signature **Date**

_____ _____
Printed Name **Date**

_____ _____
Parent/Guardian Signature (*if under 18*): **Date**

_____ _____
Parent/Guardian Printed Name: **Date**

HIPAA Regulations

I understand that **Athletic Edge Physical Therapy** complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of last bill collected.

_____ _____
Patient Signature **Date**

_____ _____
Printed Name **Date**

_____ _____
Parent/Guardian Signature (*if under 18*): **Date**

_____ _____
Parent/Guardian Printed Name: **Date**

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies(S) _____

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to **Athletic Edge Physical Therapy** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

_____ _____
Patient Signature **Date**

_____ _____
Printed Name **Date**

_____ _____
Parent/Guardian Signature (*if under 18*): **Date**

_____ _____
Parent/Guardian Printed Name: **Date**

Click to Submit Form