

PATIENT REGISTRATION AND HISTORY

1.) Patient Information

Date _____

SS# _____

Patient Name _____
Last Name

_____ First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced

Patient Employer _____

Occupation _____

Employer Phone (_____) _____

Spouse's Name _____

Whom may we thank for referring you? _____

2.) Insurance Information

Policy Holders Name _____

Insurance Co. _____

Policy # _____ Group # _____

Worker Injury:

Employer: _____ Phone _____

Address _____ Supervisor _____

Was injury/accident reported to supervisor? Y / N

Date _____ Time _____

Auto Injury

Do you have "Med Pay" on your Auto Policy: Y / N Amt. \$ _____

Adjuster _____ Claim # _____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Fox Valley Physical Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

3.) Phone Numbers

Cell _____ Home _____

Other _____

IN CASE OF AN EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4.) Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp Other

Attorney Name (if applicable) _____

5.) Patient Condition

Present Complaint (*please circle appropriate ones*)

Dizzy	Mid-back pain	Confusion
Neck pain	Low-back pain	Unbalanced
Shortness of breath	Rib pain	Fainting
Blurred vision	Chest pain	Pins & Needles
Depression	Nervousness	Tension
Feet/hands cold		

When did the symptoms appear? _____

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____

2. _____ Specialty _____

Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

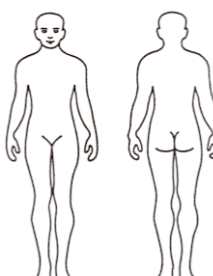
Type of pain Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come & go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6.) Health History				
Name of primary care physician _____		Date of last visit _____		
Address _____				
What treatment have you already received for your condition? <input type="checkbox"/> Medications <input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy				
<input type="checkbox"/> Chiropractic Services <input type="checkbox"/> None <input type="checkbox"/> Other _____				
Circle below <i>all</i> that apply:				
AIDS/HIV	Cancer	Hernia	Pacemaker	Stroke
Alcoholism	Diabetes	Herniated Disk	Pinched Nerve	Thyroid Problems
Anemia	Emphysema	High Cholesterol	Prostrate Problem	Tuberculosis
Arthritis	Epilepsy	Migraine Headaches	Psychiatric Care	Ulcers
Bleeding Disorders	Glaucoma	Multiple Sclerosis	Rheumatoid Arthritis	Other _____
Bronchitis	Heart Disease	Osteoporosis		
EXERCISE <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	WORK ACTIVITY <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	HABITS <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____		
Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Due Date _____				
Injuries/Surgeries you have had Description & Date _____				
7.) Medications _____				

Fox Valley Physical Medicine may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

Consent for treatment:

I voluntarily consent to the rendering of all care, including but not limited to, physical therapy, manipulative treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of such physician(s).

Medicare consent to release information:

I certify that the information given by me in applying for payment under Title XVIII and or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim.

Insurance Consent:

I understand that my insurance policy is an agreement between my carrier and myself, and that I am solely responsible for charges accrued at this facility. If my insurance denies payment for any reason, I agree to pay the entire portion of the balance or as agreed upon by this facility.

I may be unable to pay the remaining portion of my insurance responsibility, due to economic hardship as agreed upon by this facility.

Verification of Non-Pregnancy (Female patients only):

I hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. Initial _____

Patient's Signature

Print Patient's Name

If a minor, Parent / Legal Guardian