Patient Registration Form

Today's Date:_______________

Last Name:_________________________ MI:________ First Name:_________________________

Date of Birth_________________________ Social Security #_________________________

Address:_________________________ City:_______________ State:________ Zip:________

Home Phone Number:_____________________ Cell Number _________________________

E-mail address:_________________________

I prefer appointment reminders via: Text___ Message Home___ Message Cell ___

Spouse or Guardian's Information (If covered under their insurance)

Last Name:_________________________ MI:________ First Name:_________________________

Date of Birth_______________

Address:_________________________ City:_______________ State:________ Zip:___________

Home Phone Number:_____________________ Cell Number _________________________

Insurance Information – Primary, Secondary, Other

Do you have health insurance? O Yes – **Please give Insurance Card(s) to the Receptionist** O No

Primary Insurance Company Name_________________________

Name of Policy Holder for Primary Insurance _________________________ Relationship_____________

Primary Policy Holder's Home Address_________________________ City ____________ State_______ Zip_____

Secondary Insurance Company Name _________________________

Name of Policy Holder for Secondary Insurance _________________________ Relationship_____________

Secondary Policy Holder's Home Address_________________________ City ____________ State_______ Zip____

Patient's Employer Information

Patient's Employer _________________________ Phone_____________

Employer's Address _________________________ City_____________ State________ Zip_____________

Injury Cause Information

Injury occur as a result of: O Work Injury O Auto Accident O Another Party Responsible O Fall O Surgery O Sports Injury O None of the Above (chronic or general health)

Date of Injury / Accident / Surgery: ____________________

If the injury occurred at your workplace, has your employer been notified? O Yes O No

Are you represented by an attorney? O Yes (Attorney's name) _________________________ O No

Have you received therapy services during the current calendar year?

O Yes (Provider) ____________________ O No

Have you received in-home nursing and/or therapy services within the last 30 days?

O Yes (Provider)____________________ O No

Emergency Information

In case of emergency, please list the nearest living relative / friend you would like for us to contact on your behalf:

Name_________________________ Phone_______________ Relationship_________________________

How Did You Hear About Us?

O Physician Referral O Current/prior patient_________________________ O Employer/Work Comp

O TV O Radio O Newspaper O Phone Book O Online Search/Website

O Facebook O Health Plan/Insurance Directory O Other_________________________

Medical History Form

Today's Date:____________

Patient Name:____**DOB:**________________

Height:______________Weight____________

Have you ever been told you have any of the following: (please circle)

Allergies	*Angina or chest pain*	*Anxiety/Panic attacks*
Arthritis	*Asthma or other breathing problems*	*Cancer:*____________
Cirrhosis/Liver Disease	*Chemical Dependency (Drugs/Alcohol)*	*Depression*
Diabetes	*Eating Disorder (Anorexia, Bulimia)*	*Headaches*
Heart Attack	*Hemophilia or slow healing*	*High Blood Pressure*
High Cholesterol	*Kidney Disease/Stones*	*Multiple Sclerosis*
Osteoporosis	*Scoliosis Stroke*	*Tuberculosis*

Other (please describe) ____

List any Medication(s) you are allergic to:____

Any other allergies:____

Are you latex sensitive: Yes____ No_____

Past Medical Problems / Surgeries / Hospitalizations / Injuries

FOR WOMEN ONLY:

Are you currently pregnant or think you might be pregnant? O Yes O No

Are you experiencing any gynecological problems? O Yes O No

Is urine leakage a problem for you? O Yes O No

Would you like information about our Women's Health Programs? O Yes O No

Fairfield UNIVERSAL Therapy

List any PRESCRIPTION MEDICATIONS you are currently taking (or provide copy of list if available):

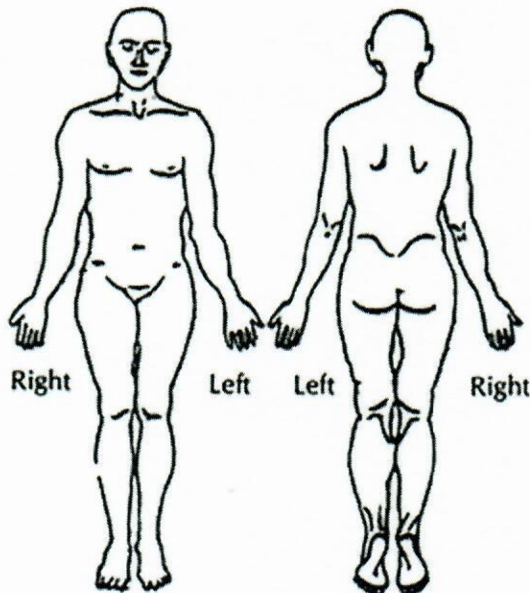
List any OVER THE COUNTER Medications you have taken in the last week:

When did problem start for which you are seeking therapy?____________________________

How did problem start? ____

Tests or treatments received for this problem (including therapy)_________________________

Pain: Please outline your pain on the diagram below



Rate your pain: (No Pain) 0 . . 1 . . 2 . . 3 . . 4 . . 5 . . 6 . . 7 . . 8 . . 9 . . 10 (Worst Pain)

Describe your pain: (check all that apply)

O Dull O Ache O Stabbing O Pins/Needles O Shooting O Burning O Numb/Tingling

O Throbbing O Twinge **Is your pain constant?: Yes_____ No_____**

Thank you for choosing Fairfield UNIVERSAL Therapy as your healthcare partner.

Please carefully read each section below, sign and date at the bottom. Our team is here to assist you if you have any questions.

CONSENT FOR TREATMENT

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist or physical therapist assistant employed by Fairfield Universal Therapy. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

NOTICE TO PATIENTS: For personal safety, do not use any equipment without a team member present

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NOTICE OF PRIVACY PRACTICES

I have read and fully understand Fairfield Universal Therapy's Notice of Privacy Practices. I understand that if I wish to receive a printed copy of the Notice of Privacy Practices, I can request it at any time. I authorize the use and disclosure of my personal health information for purposes as noted in Fairfield Universal Therapy's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PATIENT FINANCIAL RESPONSIBILITY

Fairfield Universal Therapy will contact your insurance provider and verify your benefits as accurately as possible. Please keep our team informed of any changes to your personal information and/or health insurance information so that your claims will process promptly and fully. It can take 4-8 weeks for the insurance company to process your claims.

I authorize Conilogue PT LLC dba Fairfield Universal Therapy to bill my health insurance on my behalf and I thereby assign all medical benefits to Conilogue PT LLC dba Fairfield Universal Therapy.

I understand and acknowledge that I am financially responsible for payment of services provided to me and that I will pay at the time of service, whether I am using insurance or not. This includes, but is not limited to co-payments, coinsurance, and deductibles that are not covered by my health insurance. I understand that verification of my insurance benefits is not a guarantee of payments, and that the insurance company determines benefit payments. I understand that I will receive a statement for all unpaid services if I do not pay at the time of service. If I fail to pay my account balance in full after three final statements, I understand that my account may be referred to a collection agency.

I have read and understand and agree to the above information.

Patient Name:________________________________ **Signature**________________________ **Date:**________

Legal Guardian Name:__________________________ **Signature**________________________ **Date:**_______

DESIGNATED INDIVIDUALS AUTHORIZATION

I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name ____ Relationship___________________________

Name ____ Relationship___________________________