San Tan Physical Therapy

Registration Form

Patient Name: _____ Birthdate: _____ Sex: Male / Female

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (home) _____ (work) _____ (cell) _____

Patient Social Security #: _____ Email: _____ Marital Status: Single / Mar / Div /Other

Physician Name: _____ Physician Phone #: _____ Physician Fax #: _____

Attorney Name and Phone Number: _____

Occupation: _____ Employer: _____

What will we be seeing you for? _____

Spouse Information:

Name: _____ Employer: _____

Date of Birth: _____ Phone: _____

Social Security Number: _____

Parent/Guardian Information (if patient is minor):

Name: _____ Employer: _____

Date of Birth: _____ Phone: _____

Social Security Number: _____

Emergency Contact:

Name of Person to Contact: _____ Phone #: _____

Contact Address: _____

Relationship to patient: _____

Patient/Parent/Guardian Signature: _____ Date: _____

20261 East Ocotillo Road • Suite 110 • Queen Creek, Arizona 85142
480.677.2771 • 480.677.2768 fax

San Tan Physical Therapy

Please carefully read the following statements and sign at the bottom indicating your understanding. If you have any questions please inform one of our staff members. Thank you .

Consent to Evaluation

I herby consent to the evaluation of my condition by a licensed Physical Therapist employed by San Tan Physical Therapy.

HIPAA

I understand that, under the Health Insurance Portability Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have read your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information prior to signing this consent. I understand that the organization has the right to change the Notice of Privacy Practices and that I may obtain a copy of their practices at any time.

Patient Responsibility

- It is the patient's responsibility to inform San Tan Physical Therapy of treatment and medications at their initial evaluation.
- It is the patient's responsibility to inform San Tan Physical Therapy as soon as possible if there are any change to your insurance or your medical condition.
- It is the patient's responsibility to inform San Tan Physical Therapy if the patient is under the influence of any substance or has a condition that may affect their safety while receiving treatment.

Cancellation/No Show Policy

I understand that cancellations should be made at least 24 hours prior to my scheduled appointment time, unless extenuating circumstances prevent otherwise. This will allow us to accommodate other patients in need.

Voice Mail Messages

Do we have permission to leave messages that may contain detailed information regarding your appointments, billing, or treatment on your home or cell phone voice mail? **Note**: If you do not specify either home or cell we will assume your consent is for all telephone numbers listed on your registration.

Home _____ Cell _____

My signature on this form indicates that I have read and understand each of the above patient policies of San Tan Physical Therapy. Additionally, I have addressed any concerns that I have with the policies. This form is essential to the function of San Tan Physical Therapy and I understand that by not signing this form I may be refused treatment.

_____

Patient Name (Print)

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

San Tan Physical Therapy Witness Date

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Cancellation Policy

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call **at least 24 hours in advance**. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

No Show Policy

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty dollar ($30.00) fee. This fee will be billed directly to you and will not be covered by your insurance company.

_____ _____

Patient Signature **Date**

_____

Printed Name

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Patient Information/Past Medical History Form

Patient Name: _____ Date: _____
Date of Injury/Onset of Symptoms: _____
Are you working? Yes No Retired Temporarily off work? Yes No

If yes, when did you work last _____. What is your occupation and what are the physical demands of your position? _____

_____

If you are on light duty please describe your limitations. _____

_____

What medications are you currently taking? _____

_____

What tests and/or treatments have you had for this condition (x-rays, MRI, etc)? _____

_____

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Heart Condition	☐	☐
High Blood Pressure	☐	☐	Breathing Difficulties	☐	☐
Heart Attack	☐	☐	Currently Pregnant	☐	☐
Pacemaker	☐	☐	Headaches	☐	☐
Hernia	☐	☐	Seizures	☐	☐
Dizziness Fainting	☐	☐	Skin Abnormalities	☐	☐
Asthma	☐	☐	Osteoporosis	☐	☐
Smoking	☐	☐	Stroke/CVA	☐	☐
Osteoarthritis	☐	☐	Rheumatoid Arthritis	☐	☐

Allergies: _____
Surgeries: _____
Recent Fractures: _____
Cancer: _____
Other (AIDS/HIV, Hepatitis, Polio,etc): _____

_____

_____

_____

What other health care professionals have you seen for this diagnosis (orthopedist, chiropractor, massage therapist, etc)?

_____

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Patient Information/Past Medical History Form (cont.)

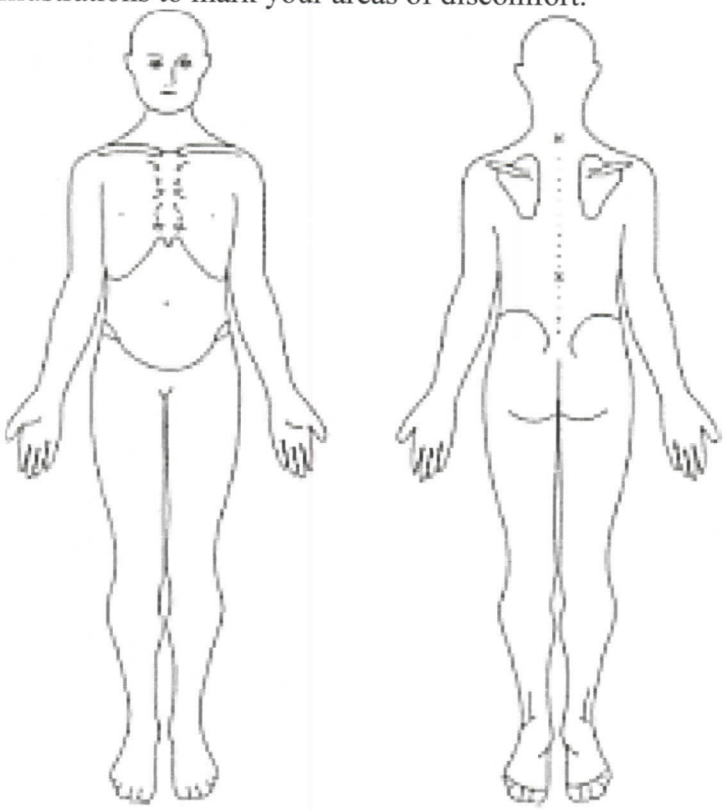
What is your main complaint? _____

_____

Please indicate your level of pain on the following number scale (0 = no pain, 10 = maximal pain):

At worst: 0 1 2 3 4 5 6 7 8 9 10 At best: 0 1 2 3 4 5 6 7 8 9 10

Please use the illustrations to mark your areas of discomfort.



Are you <u>now</u> having difficulty with any of the following because of your symptoms (please circle):

Sitting Driving Sleeping Standing Walking Bathing Dressing

Squatting Stooping Lifting Reaching Stairs Other _____

Patient Signature (Parent/Guardian): _____

Date: _____