Madison Physical and Occupational Therapy Registration

First Name ______________________________ **Last** Name ______________________________
Birthday: ______________________________ Soc.Sec Number: ______________________________
Gender: □ Male □ Female Full time Student: □Yes □No
Martial Status: □ Single □ Married □ Divorced □ Separated □ Widowed
Address (With APT. Number) ______________________________
City______________________________ State__________ Zip______________________
Home Phone______________________________ Cell Phone______________________________
Work ______________________________ Ext __________ Email ______________________
Emergency Contact ______________________________ Relationship ______________________________
Home Phone ______________________________ Work Phone ______________________ Ext__________
How did you find out about our office? ______________________________
Prescribing/ Referring Doctor ______________________________

INSURANCE INFORMATION Please give your insurance card(s)to the front desk when you hand in this form

PRIMARY INSURANCE
Insurance Company ______________________
Phone ______________________
Policy/ID ______________________
Group# ______________________
Insured Name______________________
Relationship to Insured ______________________
Social Sec. ______________ Birthdate__________

SECONDAY INSURANCE
Insurance Company ______________________
Phone ______________________
Policy/ID ______________________
Group# ______________________
Insure Name______________________
Relationship to Insured ______________________
Social Sec______________ Birthdate ______________

PRACTICE POLICY & PATIENT SIGNATURE

Cancellations: Your appointment time is exclusively for you. It is for this reason that you give us a minimum of 24 hours notice when canceling or you will be charged a **$40** fee for the appointment.

Confidentially: This office adheres to all rules regarding the confidentially of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with Medicare and/or all other insurance companies and other health care practitioner(s) by letter, phone or fax upon written permission from the patient (see below).

Only information necessary to process claims is released to insurance companies.

Patient Consent:

1. I have read and understand the cancellation policy.
2. I authorize the release of any medical information necessary to process all claim, and I authorize any staff of Madison Physical Therapy to communicate with Medicare and/ or all other health care practitioner(s) as necessary by letter, phone, or fax.
3. If assignment is accepted, I authorize and request my insurance companies to pay directly to Mark Amir or Madison Physical Therapy benefit otherwise payable to me. I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed “not medically necessary” by my insurance companies. Further, I understand that if an insurance claim is not paid with 45days, I am responsible for the full amount immediately.
4. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.
5. If Mark Amir or Madison Physical Therapy is a participating provider with Medicare and/ or any other insurance companies, I understand that I am subject to the term conditions of the Medicare and /or other insurance policies.

Signature ______________________________ Date ______________________

PATIENT MEDICAL HISTORY FORM

Patient's Name______________________ Referring Physician ___________________
Family Physician ____________________ M/F______ Height______ Weight _______
Is an attorney involved in the case? Yes No Have you had surgery for this injury? Yes No
Type of Surgery _____________________ In which Hospital ______________________
What is your primary problem: ____?

Are you currently taking any prescription or non-prescription medication? Yes No

Anti- Inflammatory	Yes No	______________________________________
Muscle Relaxant	Yes No	______________________________________
Pain Medication	Yes No	______________________________________
Other	Yes No	______________________________________

Have you had any of the following medical or rehabilitative service for this injury?

	Yes	No		Yes	No		Yes	No
General Doctor	___	___	Chiropractor	___	___	MRI	___	___
Neurologist	___	___	Physical Therapist	___	___	Myelogram	___	___
Orthopedist	___	___	Occupational Therapist	___	___	EMG/NCY	___	___
Emergency Room	___	___	Acupuncture	___	___	Bone Density	___	___
Pain Management	___	___	Massage Therapist	___	___	Injections	___	___
Podiatrist	___	___	CT scan or X-Ray	___	___	Vax- D	___	___

Do you have or ever had any of the following?

	Yes	No		Yes	No
Allergies	____	____	Osteoporosis	____	____
Anemia	____	____	Parkinson's disease	____	____
Arthritis /Swollen Joints	____	____	Pacemaker	____	____
Asthma, Bronchitis, Emphysema	____	____	Severe Headaches	____	____
Blood Clots	____	____	Shortness of Breath	____	____
Bowel or Bladder Problem	____	____	Stroke / TIA	____	____
Cancer/ Chemotherapy Radiation	____	____	Thyroid Dysfunction/ Goiter	____	____
Coronary Heart Disease or Angina	____	____	Varicose Veins	____	____
Diabetes	____	____	Vision or hearing Difficulties	____	____
Dizziness or Fainting	____	____	Weakness	____	____
Emotional/ Psychological Problem	____	____	Weight Loss/ Energy Loss	____	____
Epilepsy / Seizures	____	____	Ankle Injury/ Surgery	____	____
Gout	____	____	Elbow or Hand Injury/ Surgery	____	____
Heart Attack or Surgery	____	____	Knee or Hip Injury/ Surgery	____	____
Hernia	____	____	Lower Back Injury/ Surgery	____	____
High Blood Pressure	____	____	Neck Injury/ Surgery	____	____
Infectious Disease	____	____	Pins or Metal Implants	____	____
Joints Replacement	____	____	Recent Pregnancy or Cesarean Section	__	____
Multiple Sclerosis	____	____	Currently Pregnant	____	___
Numbness or Tingling	____	____	Do You Smoke	____	___

Other not listed conditions: ____

Patients/ Guardian Signature ___________________________ Date _________________