PATIENT REGISTRATION AND HISTORY

Patient Name (please print): _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Sex: Male ☐ Female ☐ **Age:** _____ **D.O.B.**_____ __ **SS#**_____

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Occupation: _____ **Employer:** _____

Employer Address: _____ **City, State, Zip:** _____

Employer Phone: _____

Spouse Name: _____ **D.O.B.** _____ **SS#**_____

Occupation: _____ **Employer:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

INSURANCE INFORMATION

Who is responsible or the sole policy holder for the primary insurance? _____

Relationship to patient: _____ **D.O.B.** _____ **SS#** _____

Employer: _____ **Primary Insurance:** _____

Contra ct # _____ **Group #** _____

Secondary Insurance: _____ **Policy Holder of 2nd insurance:** _____

D.O.B. _____ **SS#**_____ **Employer**_____

Contract # _____ **Group #** _____

ASSIGNMENT AND RELEASE

I, the undersigned, verify that I (or my dependent) have Insurance coverage and assign directly to Atlas Physical Therapy, Inc. 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 herby authorize Atlas Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ **Relationship:** _____

Date: _____

MEDICAL HISTORY

Please answer "Yes" or "No" to indicate if you *have* or *had* any of the following:

Infectious Disease	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Heart Conditions	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Diabetes/Low Blood Sugars	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Bowel or Bladder Incontinence	☐ Yes	☐ No	Skin Lesions (any open sores)	☐ yes	☐ No

Please list all surgeries you have had: _____

_____

Have you taken any special medical test (CAT scan, MRI, EKG, X-rays, etc.) _____

Have you had any orthopedic problems? _____

Family Physician: _____ Date of last visit _____

Orhopod: _____ Date of last visit _____

Podiatrist: _____ Date of last visit _____

Why were you referred to physical therapy? _____

Is this auto related? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

Other? _____

Medications:

Please list all medications, including over the counter medications that you are taking:

_____

Allergies:

Please indicate if you are allergic to the following:

Adhesive Tape latex Other: _____

Who can we thank for referring you to us today? _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give permission to Atlas Physical Therapy, Inc. to administer and perform treatments and procedures as may be deemed necessary by my physician.

Patient Signature: _____ Date: _____