Atlantic Rehab Physical Therapy
Patient Registration Form
**** THESE FORMS ARE FRONT AND BACK ****
**** Please be sure to fill out all forms COMPLETELY before returning to front desk ****

Name: Last _____ First_____ MI_____
Address _____
City, State, Zip _____
Home Phone _____Cell Phone _____
Social Security Number _____
Date of Birth _____ Age: _____
Email Address _____
Employed: FT PT R N/A Marital Status: M S D W Student: FT PT N/A
Referring Physician _____ Phone _____
Primary Care Physician _____ Phone _____
Contact of Emergency _____Number_____

How did you hear about us? (Please check one) Doctor____ Insurance____ Self ____ Website____ Friend (Who) _____

Treatment for your **current chief complaint** have included: (Circle all that apply)

Physical Therapy	Chiropractic Care	Pain Management	Mechanical Traction	Massage
Injections	Aquatic Therapy	Brace/Tape	Surgical Intervention	Personal Training
Athletic Training	No treatment received yet	Other:_____		

HEALTH INSURANCE INFORMATION

Primary Insurance _____**Member number** _____
Group#:_____ **Who is the primary account holder:** Self Spouse Parent

Secondary Insurance _____**Member number** _____
Group#:_____ **Who is the primary account holder:** Self Spouse Parent

Information on Insurance Policy Holder (If other than self)

Name: Last _____ First_____ MI_____
Social Security Number _____ Date of Birth _____
Address _____ City/State/Zip _____

Insurance Benefit Information: _____

_____

_____

_____

_____

_____

TURN OVER

Under Medicare and the Maryland practice act we are required to obtain a complete medical history on all patients. This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Hand Dominance: R / L Height: _____ Weight: _____

If accident, circle place where occurred: Home Auto Work Sports Other

Have you had any recent falls in the past year? _____ Were you injured? _____

Next Doctor's Visits ____/____/_____ Occupation: _____ Current Work Status: _____

Do you have any lifting restrictions? Y / N

What is the reason for your visits today? _____

Briefly describe how your problem began: _____

What goals would you like to achieve through therapy? _____

Date of onset/injury: ____/____/____ Date of surgery: ____/____/____ Type of Surgery: _____

Have any diagnostic tests have been performed for this problem? (Circle all that apply)

X- Rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Bloodwork Other: _____

Have you had similar symptoms in the past? Y / N Have you received Home Health PT prior to coming here? Y / N

Please check if you have or have had any of the following conditions:

☐ Allergies	☐ Allergic to Latex	☐ Amputation	☐ Anemia
☐ Angina	☐ Asthma	☐ Ataxia	☐ Bell's Palsy
☐ Blood Clot/Emboli	☐ Bowel/Bladder Problems	☐ Bronchitis	☐ Carpal Tunnel Syndrome
☐ Cellulitis	☐ Cerebral palsy	☐ Concussion	☐ COPD
☐ Coronary Heart Disease	☐ Depression	☐ Dizziness or Faintness	☐ Drink Alcohol
☐ Emphysema	☐ Energy Loss	☐ Epilepsy/Seizures	☐ Epstein-Barr
☐ Gout	☐ Guillain-Barre Syndrome	☐ Headache, Severe	☐ Hearing Difficulties
☐ Heart Attack	☐ Heart Disease	☐ Hernia	☐ High Blood Pressure
☐ Intractable Pain	☐ Kidney Disease	☐ Lipedema	☐ Low Blood Pressure
☐ Low Blood Sugar	☐ Lumpectomy	☐ Lupus	☐ Lyme Disease
☐ Lymphedema	☐ Mastectomy	☐ Multiple Sclerosis	☐ Neurological Issues
☐ Osteoarthritis	☐ Osteoporosis	☐ Oxygen Dependency	☐ Pacemaker
☐ Parkinson's Disease	☐ Pneumonia	☐ Pregnancy, Current	☐ Rheumatoid Arthritis
☐ Sciatica	☐ Shortness of Breath	☐ Sleep Apnea	☐ Sleeping Problems
☐ Spinal Stenosis	☐ Stroke/TIA	☐ Thyroid	☐ Tobacco Use
☐ Torticollis	☐ Varicose Veins	☐ Vasculitis	☐ Vertigo/Balance
☐ Vision Difficulties	☐ Weakness	☐ Weight Loss	☐ Women's Health Issue(s)

Does your daily routine, or work, aggravate your condition?

- ○ No
- ○ I am unable to participate in my normal routines or work
- ○ My routine/work aggravates my condition 1 day per week
- ○ My routine/work aggravates my condition about 2 days per week
- ○ My routine/work aggravates my condition 3 or more days per week
- ○ My routine/work aggravates my condition every day, but I try to cope

How often do you exercise?

- ○ Never
- ○ Usually once per week
- ○ Usually twice per week
- ○ Usually 3 times per week
- ○ 4 or more times per week

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Please select which area of the body you are coming in for:

- [ ] Abdomen
- [ ] Ankle, Left
- [ ] Ankle, Right
- [ ] Arm, Left
- [ ] Arm, Right
- [ ] Buttock, Left
- [ ] Buttock, Right
- [ ] Chest, right
- [ ] Chest, left
- [ ] Chest, bilateral
- [ ] CRPS, bilateral
- [ ] CRPS, left
- [ ] CRPS, right
- [ ] Elbow, Left
- [ ] Elbow, Right
- [ ] Feet/Toes, Left
- [ ] Feet/Toes, Right
- [ ] Groin
- [ ] Hands/Fingers, All
- [ ] Hands/Fingers, Left
- [ ] Hands/Fingers, Right
- [ ] Head, Left
- [ ] Head, Right
- [ ] Hip, Left
- [ ] Hip, Right
- [ ] Hip, Both
- [ ] Incontinence
- [ ] Jaw, Left
- [ ] Jaw, Right
- [ ] Knee, Left
- [ ] Knee, Right
- [ ] Knee, Both
- [ ] Leg, Left
- [ ] Leg, Right
- [ ] Lower Back, Left
- [ ] Lower Back, Right
- [ ] Lower Back, Center
- [ ] Neck, right
- [ ] Neck, left
- [ ] Neck, bilateral
- [ ] Pelvic Floor
- [ ] Pelvis
- [ ] Rectal
- [ ] Shoulder, Left
- [ ] Shoulder, Right
- [ ] Upper Back, Right
- [ ] Upper Back, Left
- [ ] Upper Back, Center
- [ ] Vagina
- [ ] Wrist, Left
- [ ] Wrist, Right
- [ ] None Of These

Please Select Any Topics Related to Your Medical History

- [ ] Cancer
- [ ] Pre-Diabetes
- [ ] Diabetes, Type 1
- [ ] Diabetes, Type 2
- [ ] I have received P.T. or O.T. treatment at home
- [ ] I am a caregiver for someone else
- [ ] I live alone
- [ ] I use a cane
- [ ] I use a walker
- [ ] I use a wheelchair
- [ ] Infectious Disease
- [ ] My home has stairs
- [ ] Other Important Issue(s)
- [ ] Other Surgery

Does your condition impact your ability to do your job?

- ○ I am retired
- ○ The condition prevents me from working
- ○ I can only work part time
- ○ I can work, but with great difficulty
- ○ I can work, with minor difficulty
- ○ The condition does not impact my ability to work
- ○ Not applicable

Does your condition impact your ability to attend school?

- ○ The condition prevents me from attending school
- ○ I am in school, but the condition has a big impact
- ○ I am in school and the condition has minor impact
- ○ School is normal, but I can't participate in sports
- ○ School is normal, no impact
- ○ Not applicable

Please circle any that you may have/wear: Glasses Contacts Dentures Pacemaker Metal Implant Hearing Aides

List all previous surgeries and dates: _____

_____

Describe what type of pain/discomfort you feel related to your injury.

- [ ] Aching
- [ ] Burning
- [ ] Constant
- [ ] Cramping
- [ ] Deep
- [ ] Dull
- [ ] Heavy
- [ ] Numb
- [ ] Pins and Needles
- [ ] Stabbing
- [ ] Throbbing
- [ ] Variable
- [ ] Weak

TURN OVER

What was your level of pain/discomfort when the condition first occurred?

0/1=No Pain/Discomfort 10=Worst Pain/Discomfort Ever

0 1 2 3 4 5 6 7 8 9 10

What is your pain/discomfort level today when it's at its worst?

0/1=No Pain/Discomfort 10=Worst Pain/Discomfort Ever

0 1 2 3 4 5 6 7 8 9 10

What is your pain/discomfort level today when it's at its best?

0/1=No Pain/Discomfort 10=Worst Pain/Discomfort Ever

0 1 2 3 4 5 6 7 8 9 10

What worsens your symptoms?

- ☐ Reaching back
- ☐ Lying flat
- ☐ Getting up out of bed
- ☐ Dressing and grooming
- ☐ Cooking
- ☐ Carrying items
- ☐ Climbing stairs
- ☐ Sitting
- ☐ Twisting
- ☐ Lifting anything
- ☐ Lifting heavy weights
- ☐ Pulling
- ☐ Raising arm over the head
- ☐ Looking up/down
- ☐ Walking
- ☐ Bending

What relieves your symptoms?

- ☐ Ice
- ☐ Heat
- ☐ Stretching
- ☐ Exercise
- ☐ Pain medication
- ☐ Lying flat
- ☐ Avoiding activity
- ☐ Nothing

List all medications/supplements/vitamins/OTC (over the counter) you currently take including dosage and frequency. This MUST be a completed before your evaluation:

Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____
Name: _____ **Frequency:** _____ **Dose:** _____

List all allergies that you may have: _____

_____

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Atlantic Rehab Physical Therapy

OFFICE POLICIES

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do here by agree and give my consent for Atlantic Rehab, Inc to furnish medical care and treatment to **(print name here)** _____ considered necessary and proper in diagnosing or treating his/her condition.

Patient Signature: _____ Date: _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled, including private insurance and/or any other health plans to Atlantic Rehab, Inc. If my current policy prohibits direct payment to the provider, I hereby also instruct and direct my insurance company to make the check out to me and mail to: 5 Crain Hwy., suite 103 Glen Burnie, MD 21061. I authorize Atlantic Rehab, Inc to deposit checks received on patient's account when made out to the patient. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize Atlantic Rehab, Inc to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient Signature: _____ Date: _____

SCHEDULING AND CANCELLATION POLICY

Office Appointments are scheduled for your convenience, to minimize waiting and to enable you to incorporate these appointments into your schedule. Not showing up for scheduled appointments without prior notice is unfair to other patients who are waiting for appointments. Therefore, if you are unable to keep a scheduled appointment, we require 24 hour notice for canceling appointments. Failure to give notice will result in a $25.00 charge for missed office visits. This fee is due prior to your next visit.

Patient Signature: _____ Date: _____

FINANCIAL POLICY

1. All referrals, co-pays and balances owed on account must be given to the secretary when you sign in at the front desk for your appointment. Failure to provide a referral when your insurance requires one will result in rescheduling of your appointment. **Keeping your referral updated is the patient's responsibility.**
2. Returned checks will be assessed a ***$25.00*** cash fee.
3. Patient balances are payable within **30 days** of receipt of the bill. A **1.8%** monthly interest fee will be assessed for all outstanding balances. Balances that remain outstanding beyond 90 days unless payment arrangements are made will be sent to collections.
4. We accept VISA and MASTERCARD, CHECKS, MONEY ORDERS, AND CASH.
5. I understand, I am responsible for any balance not covered by or allowed by my insurance.

Patient Signature: _____ Date: _____

HIPPA POLICY ACKNOWLEDGEMENT

I have reviewed this practices' Notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual right, how I may exercise these rights, and the practices legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. A copy is available upon my request of the Notice of Privacy Practices for my records.

I, hereby acknowledge and understand receipt of the information regarding my obligations as a patient.

Patient Signature: _____ Date: _____
Relationship to patient (if signed by personal representative of patient) _____