Spine and Orthopedic Rehab **Patient Registration Form**

Appointment Date _____ Office 1 2 3 Diagnosis 1. _____ 2. _____
(office use only) (office use only)
3. _____4. _____

Patient Name _____
First MI Last (Name as appears on Insurance Card)

Address _____email _____

City _____State _____ Zip _____ Date of Birth _____

SS# _____ Gender M F Marital Status: Married Single Divorced Widowed

Phone Home (_____)_____ Cell _____ Work _____

Emergency contact _____ phone _____ relationship _____

Referring Dr. _____ UPIN _____ Next Appt. _____
(office use only)

Primary Dr. _____ Next Appt. _____

Occupation _____ Employer _____

Have you had Physical Therapy this calendar year? Yes _____ No _____ Where _____

Are you currently receiving **ANY** home health care/benefits? Yes _____ No _____

Is Injury due to an accident? Yes _____ No _____ Date of Injury _____

Auto accident _____ Work related _____ Personal _____ Is an attorney involved? Yes ____ No _____

Attorney Name _____ Firm _____

INSURANCE INFORMATION

Primary Insurance _____ Phone _____

Group # _____ Subscriber ID _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Relationship to Patient _____ Self _____ Spouse _____ Parent

Secondary Insurance _____Phone _____

Group # _____ Subscriber ID _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Relationship to Patient _____ Self _____ Spouse _____ Parent

Spine and Orthopedic Rehab **Patient Signature Form**

Ins. Type	Reported Benefits (not guaranteed)		Patient Initials
____ Commercial _____			
____ Medicare	_____	Deductible	_____
____ Liability			
____ Work. Comp.	_____	CoPay – CoIns.	_____
____ Self Pay			
____ Other	_____	Max Benefits	_____
		Office policies	_____

Insurance Authorization and Assignment

I hereby authorize Spine and Orthopedic Rehab (SOR) to release all medical records and information with respect to myself, or my dependents, which may have a bearing on the benefits payable by a payer for treatment services rendered by SOR. I understand that I cannot retract this authorization for the release of medical records until my treatment account balance is fully satisfied.

I understand I am financially responsible to SOR for any co-pays, deductibles or charges not covered by any insurer. I acknowledge that SOR can charge a service to my account in the event that I remit payment for services with a check that is returned due to insufficient funds. I understand SOR reserves the right to collect all charges related to patient accounts placed into collections including but not limited to collection agency fees, attorney fees and court costs.

I request payments from Medicare and other benefits to be made to SOR on my behalf or my dependents for any treatment services rendered. I certify the information given by me in applying for payment under title XVII of the Social Security act, if applicable, is correct.

All patients including those without insurance are required to make payments of at least $35/week and when discharged, monthly payments of $75. If this is a hardship, arrangements will need to be made with the financial department.

I acknowledge that SOR reserves the right to charge me personally for visits canceled without 24-hour notice.

Patient Name (Printed) _____

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____
(If patient is under 18 y/o)

The people listed below can get information about my treatment or appointments. Should you desire to reverse this permission, it must be revoked IN WRITING and put on file in your chart.

1._____ relationship _____

2._____ relationship _____

3._____ relationship _____

I acknowledge that I have reviewed SOR's Notice of Privacy Practices and been provided a copy, if requested.

_____ _____ _____
Signature of patient or authorized legal representative Date relationship to patient

Spine and Orthopedic Rehab **Patient History Form**

Patient Name _____

Do **you** have a history of: (check yes or no for each)

	Y	N	Comments		Y	N	Comments
Cancer				Thyroid Disease			
Headache				HIV			
Asthma				Heart Disease			
Diabetes				High Blood Press.			
Seizures				Circulation			
Fractures				Pacemaker			
Sprain/Strain				Bladder			
Joint Replace				Digestion			
Metal Implants				Weight loss/gain			
TMJ-Jaw Pain				Night Pain			
Dizziness				Osteoporosis			
Are you pregnant?				Hepatitis			

List any other health problems _____

_____

_____

Please list all medications and reason/condition:

Medication	Reason	Medication	Reason
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Please list surgeries and year performed:

Surgery	Year	Surgery	Year	Surgery	Year
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

Do you exercise?

Cardiovascular ____days/week _____ minutes/day walk run bike elliptical other _____

Weight lifting ____ days/week

Yoga _____ days/week Pilates _____ days/week

Other: