Patient Registration

Patient Information

First Name: ________________________________ Last Name: _________________________________ Middle Initial: _______

Address: ____ City, State, Zip: _______________________________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: _______________________

Birth Date: _____________________ Social Security Number _______________________ Gender: _____ Male _____ Female

Employed: _____ Yes _____ No If yes, name of business: ____

Student: _____ Full Time _____ Part Time Marital Status: _____ Married ____ Single

Email Address: ____

We remind patients of appointments through voice and text messages. Do you prefer _____ voice _____ text _____ none

If voice which phone number _____ home _____ cell _____ work

Responsible Party (If someone other than patient or if patient is a under 18 years of age)

Name: ___________________________________ Relationship: _______________ Phone Number: _______________________

Address: ____ City, State, Zip: __________________________________

Employer: ____ Phone Number: _______________________

Birth Date: _____________________ Social Security Number _______________________

Doctor Information

Referring Doctor/Specialist: _________________________________ Primary Doctor: __________________________________

Surgery Date: ____________ Next Appointment Date with Referring Doctor/Specialist: _________________________________

Have you had **home health** (for any reason) in the last 6 months? _____ Yes _____ No

When were you discharged from home health (last date they were there)? Date: _______________________________________

Emergency Contact

Name: ____ Relationship: ________________________

Phone Number: _______________________ Alternate Number: _______________________

How did you get hurt?

If injury is related to employment and you are being seen through Workers Compensation, we will need your case manager name and telephone number. We must obtain approval from your case manager **before** you begin your physical therapy visits.

Injury area: ____

Case Manager: ____ Phone Number: _____________________________

Are you currently involved in a **workers compensation liability lawsuit**: _____ Yes _____ No

If injury is related to a Motor Vehicle Accident and you are being seen through Auto Insurance (Med Pay), you must provide us with the insurance company, contact name, telephone number and claim number. We must obtain approval **before** you begin your physical therapy visits.

Injury area: ____

Auto Insurance Company: _________________________________ Claim Number: _______________________________

Contact Name: ____ Phone Number: _____________________________

Are you currently involved in a **motor vehicle liability lawsuit**: _____ Yes _____ No

If you are an athlete and were hurt in practice or a game and can use school/college insurance, you must have a signed injury report from your school/college **before** you begin physical therapy visits. If you have medical insurance, it will be your primary insurance and the school/college insurance will be your secondary.

Injury area: ____

School/College: ____________________________ Contact Name: ___________________ Phone Number: _____________

If you were injured in any other way please describe: ____

____

If the above questions do not apply to you and your diagnosis was a gradual onset please initial. _______________

Patient Medical History

General Health Status: (Rate your overall health) _____ Excellent _____ Good _____ Fair _____ Poor

Please provide your current __________ Height __________ Weight

Do you have a Pacemaker? _____No _____ Yes Are you pregnant? _____ No _____ Yes

Do you use tobacco? _____ No _____ Yes _____ Occasionally _____ Daily _____ Socially

Do you drink alcohol? _____ No _____ Yes _____ Occasionally _____ Daily _____ Socially

Surgical History (as related to this condition)**:**

____ Date ______________________

____ Date ______________________

____ Date ______________________

Allergies: (Check all that apply)

_____ Aspirin _____ Latex _____ Lithium _____ Other ____

Diagnostic Testing for this Injury / Episode: (Check all that apply)

_____ MRI _____ CT Scan _____ EMG / NVC _____ Other ____

Who have you seen for this Injury / Condition: (Check all that apply)

_____ Emergency Room Care _____ General Practitioner _____ Physical Therapist _____ Occupational Therapist
_____ Chiropractor _____ Massage Therapist _____ Orthopedist _____ Neurologist
_____ Podiatrist _____ Other ___________________________

Have you ever had Physical or Occupational Therapy?

When? ___________________________________

Where? ___________________________________

For How Long? _____________________________

Have you ever been seen by a Chiropractor?

When? ___________________________________

Where? ___________________________________

For How Long? ___________________________

Current Medications (list below or provide copy) **:**

Non-Prescription: ____

Prescription: ____

Medical History (Check if you have or have had)

_____ Cancer _____ Diabetes _____ AIDS _____ Asthma _____ Muscular Dystrophy
_____ Depression _____ Cystic Fibrosis _____ Glaucoma _____ Emphysema _____ Circulation Problems
_____ Heart Disease _____ Heart Attack _____ Head Injury _____ Kidney Disease _____ Rheumatoid Arthritis
_____ Osteoporosis _____ High cholesterol _____ Lyme's Disease _____ Skin Disorders _____ High Blood Pressure
_____ Stroke _____ Ulcers _____ Infections _____ Thyroid Disorder _____ Low Blood Pressure
_____ Multiple Sclerosis _____ Blood Disorder _____Prostate Disease _____ Lung Disorders _____ Parkinson's Disease
_____ Broken Bones _____ Liver Disease _____Seizures _____ Other _____________________________

Family History: (Check box if anyone in your immediate family has or had any of these)

_____ Heart Disease _____ Stroke _____ Cancer _____ High Blood Pressure
_____ Diabetes _____ Arthritis _____ Osteoporosis _____ Pulmonary / Lung Disease

By signing this form I agree that the information given is true.

Signature of Patient or Parent/Guardian**:**:____ Date: _______________________

Patient Date of Birth: _______________________ Therapist Initials: ________________

Payment Financial Agreement

JPT will verify insurance as a courtesy and discuss those benefits with you. Please note that we are not always quoted accurate information by insurance carriers and you are ultimately responsible for knowing and understanding your benefits. **We collect deductibles in full**. **Copays are due at time of visit.** If there is co-insurance, we collect an **estimated** weekly amount that will pay toward your total co-insurance balance. Once all insurance has processed, you will receive a final bill for remaining co-insurance due.

"In the event my account becomes past due and must be placed for collection, I agree to be responsible for any reasonable collection agency fees (40%), court costs and attorney fees. A photocopy of these assignments shall be valid as the original."

Signature of Patient or Parent/Guardian**:** ________________________________ Date: _______________

If Patient is under 18 years of age, a Parent/Guardian must sign this agreement.

Notice of Privacy Practice and Release of Patient Information

I am aware of the Notice of Privacy Practices (HIPPA) laws and Jones Physical Therapy's confidentiality procedures. I hereby authorize Jones Physical Therapy to give the following people information concerning my appointment time(s), insurance benefits and/or financial agreement, treatment plan, and any other information regarding my account unless otherwise stated.

____ ____

Name and Relationship Name and Relationship

Signature of Patient or Parent/Guardian**:** ________________________________ Date: _______________

If Patient is under 18 years of age, a Parent/Guardian must sign this agreement.

Care and Consent

I hereby agree and give my consent of care to Jones Physical Therapy and Sports Medicine. I understand manual treatments may include ASTYM, functional dry needling, joint mobilization, soft tissue mobilization and/or Primal Reflex Release Technique (PRRT) and that no guarantee or assurance has been made as to the results of these treatments and that it may not cure my condition. With my signature, I hereby consent to the performance of the treatments and to any measures necessary to correct complications which may result from them.

Signature of Patient or Parent/Guardian**:** ________________________________ Date: _______________

If Patient is under 18 years of age, a Parent/Guardian must sign this agreement.