PATIENT REGISTRATION

(Please print and complete these 2 forms in full. Bring to 1st appointment.)

Last Name: ____________________ First: ____________________ Middle: __________ DOB:____/_____/_______

Street Address: ____________________ City: ____________________ State: ________ Zip Code: ______________

SSN: ________________ Home Phone:________________ Work #: ________________ Cell #: ________________

Employer: ____

Emergency contact: ____________________ Relationship: ________________ Phone :________________

Referring Dr: ____________________ Referring Clinic: ______________________________

Primary Care Dr: ____________________ Primary Care Clinic:______________________________

PRIMARY INSURANCE BENEFITS

Insurance:____ Phone : ________________

Member ID #________________ Group # :____________ Policyholder Name:______________________________

Policyholder SSN :______________________ Policyholder Employer:______________________________

Policyholder Sex: M F Policyholder DOB : ____________ Relationship to patient: ______________________

WORKERS COMPENSATION, AUTO ACCIDENT, OR PERSONAL LIABILITY

How were you injured? (circle) Work Auto Liability Claim or File #: ______________ Injury/Accident Date: ________________

Adjustor Name:______________________ Adjustor Phone: ________________ Ext.: ____________

Work Comp/Auto/ Liability Insurance Name: ______________________________ Phone: ________________

Insurance Address : ____

Employer at time of injury:______________________________ Employer Phone: ________________

Employer Address:____

Attorney Name: ____

Attorney Address: ______________________________ Attorney Phone: ________________

SECONDARY HEALTH INSURANCE - IF APPLICABLE

Insurance Name: ____ Phone: ________________

Member ID #:________________ Group #:______________ Policy Holder Name: ______________________

Sex: M F DOB: ____/_____/_______ Relationship to patient: ______________ Subscriber's employer: ________________

Record Release: I hereby authorize the release of any information by Kinetic Physical Therapy Institute, Inc. to my referring doctor and insurance company. Furthermore, I authorize the release of any information from my referring doctor to Kinetic Physical Therapy Institute, Inc.
Assignment of Benefits: I hereby authorize payment of medical benefits to Kinetic Physical Therapy Institute, Inc. for services rendered to me and/or my dependents.
Medicare Authorization: I request that payment of authorized Medicare benefits be made to me or on my behalf to Kinetic Physical Therapy Institute, Inc. for any services furnished to me by that clinic. I authorize any holder of my hospital medical information released to the health care financing administration services. I permit a copy of this authorization to be used in place of the original. I hereby authorize Kinetic Physical Therapy Institute, Inc. to treat as prescribed.
I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in the status of the above information.
I hereby authorize Kinetic Physical Therapy Institute, Inc. to treat me and/or my dependent. I have read and understand all of the foregoing.

PATIENT SIGNATURE:______________________________ **DATE**: ________________

(Patient must be 18 years old or parent/guardian must sign)

KINETIC PHYSICAL THERAPY INSTITUTE MEDICAL HISTORY

(Please print and complete this form and Patient Registration form in full. Bring to 1st appointment.)

Date:___/___/____ Name: ______________________________ DOB:___/___/____ Age:______

Height: ____'____" Weight: ______ lbs. Sex: M or F Smoker: Yes or No Pregnant: Yes or No

Referring Physician:________________________ Primary Physician: ____________________

Reason for visit/pain complaints: ____

Date of Injury/Onset:____/___/____ Cause of Injury: Auto Work Sports Unknown Other ________

____

Surgery Date(if applicable):___/___/____ Describe:____________________________________

Are symptoms (circle): Constant Intermittent Increasing Decreasing No Change

Please indicate by circling "Yes" or "No" if you have ever been diagnosed with any of the following:

Tuberculosis No Yes Cancer No Yes Epilepsy No Yes Bowel/Bladder Problems No Yes

Heart Cond. No Yes Stroke No Yes Hepatitis No Yes

Respiratory No Yes Arthritis No Yes Diabetes No Yes

Any Previous Surgeries :____

Current Medications:____

X - Rays: __________ CT - Scan _______ MRI _________ Other ______________________

Please CIRCLE or describe what you want to accomplish from therapy (Your Goals/Limitations):

Improve sleep Decrease pain Sitting/Standing Reaching/Lifting Stairs Recreation Walking

Other ____

Please CIRCLE or describe any prior treatments or self care for this condition:

Chiropractic Heat Cold Exercise None Other ______________________________

Physical Therapy: ____

Please indicate your pain rating between 0 (no pain) and 10 (worst pain imaginable):

Lowest rating you experience: ________ Highest: ________

Are you currently working? Yes No Restrictions? Yes No

Employer ______________________________

Job Title _______________________________

Hours/Week ______ Full Duty ? Yes No

Missed work days for condition:______________

Do you have a: (Circle) QRC and/or Attorney ?

QRC Name: _____________________________

QRC Phone:_____________________________

Attorney Name :__________________________

Attorney Phone: _________________________

Therapist Only:

____

____

____

____

____

Using the diagram below indicate where you are experiencing symptoms (X=pain //= Numbness/Tingling)