Function 1st PHYSICAL THERAPY

PATIENT REGISTRATION

Section I: Personal

Date: ______________________

Name: ______________________ **Social Security #:** ______________________

Address (No P.O. Box)**:** ______________________ **Apt/Unit/FL:** _____ **City** ______________ **State** ________

Zip Code __________ - __________ **Home Phone:** (____) ______________ **Cell:** (____) ______________

Email: ______________________ **Date of Birth** ____/_____/_____ **Age** ______ **Gender:** Female Male

Marital Status: ______________ Single Married Divorced Widow **Are you a minor?** Yes No

Guarantor Information:
Mother Father Spouse Partner
Name ______________________
Address ______________________
City/State/Zip Code ______________________
Date of Birth ____/_____/_____

Guarantor Information:
Mother Father Spouse Partner
Name ______________________
Address ______________________
City/State/Zip Code ______________________
Date of Birth ____/_____/_____

Emergency Contact: **Name** ______________________

Telephone (____) ______________ **Relationship** ______________________

Is this a Work Related Injury? Yes No **Date of Injury:** ____/____/____ **Note:** Assure you complete Section II.

Is this a Motor Vehicle Collision? Yes No **Date of Injury:** ____/____/____ **Note:** Assure you complete Section II.

Section II: Accident Information

Type of Accident: Work Auto Home Other (Specify)**:** ______________________

To whom have you made a report of your accident? Workers' Compensation Auto Insurance Other

Insurance Carrier: ______________________

Billing Address: ______________________ **City:** ______________ **ST** ______ **Zip Code:** ______________

Claim#: ______________ **Contact Person:** ______________________ **Telephone:** (____) ______________

Attorney Information (if applicable): ______________________ **Telephone:** (____) ______________

Address: ______________________ **City:** ______________ **ST** ______ **Zip Code:** ______________

Section III: Insurance Information

Primary Insurance:
Self Spouse Father Mother
Insurance Name ______________________
Name of Policy Holder ______________________
ID # ______________________
Group #

Primary Insurance:
Self Spouse Father Mother
Insurance Name ______________________
Name of Policy Holder ______________________
ID # ______________________
Group # ______________________

Section IV: Employment

Employment Information:
Self Spouse Father Mother
Employer ______________________
Address ______________________
City/State/Zip Code ______________________
Work Phone# (_____) ______________________
Occupation ______________________

Employment Information:
Self Spouse Father Mother
Employer ______________________
Address ______________________
City/State/Zip Code ______________________
Work Phone# (_____) ______________________
Occupation ______________________

Section V: Medical History

Weight ____________________

Do you smoke? Yes No If yes, how much/often?

____

Do you drink alcohol? Yes No If yes, how much/often?

____

Do you use any illegal drugs? Yes No If yes, please describe:

____

Do you have any allergies? Yes No If yes, please describe:

____

Please CHECK any of the following conditions that you have had or currently have:

Asthma	Back Disorder	High Blood Pressure	Paralysis, muscle weakness
Diabetes	Broken Bone	Nervous Disorder	Appendicitis
Jaundice	Dislocation	Cancer	Foot Trouble

List of recent/current medications:

NAME

List any surgeries you have had:

PROCEDURE	YEAR	SURGEON

Section VI: Assignment and Release

AUTHORIZATION TO LEAVE A MESSAGE ON VOICEMAIL/ANSWERING MACHINE:

I hereby authorize Function1st Physical Therapy, LLC to leave a message on my voicemail /answering machine to confirm appointments, leave insurance and/or medical information. ________ (INITIALS)

CANCELLATION / NO SHOW POLICY:

I hereby understand that I am to cancel / reschedule an appointment at least 24 hours prior to scheduled appointment. Otherwise, I will be assessed a cancellation fee based on type of treatment. __________ (INITIALS)

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES:

I hereby authorize Function1st Physical Therapy, LLC Centers to release any information acquired in the course of my therapy treatment. ________ (INITIALS)

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: ***(Go to *Workmans' Comp Section* if Work Related Injury)***

I hereby authorize my insurance company to forward payment directly to Function1st Physical Therapy, LLC for services rendered. I acknowledge and understand that I am responsible for all of the charges of the services rendered to myself or family member listed within my insurance carrier. I, as insured, remain responsible for prompt payment of all services regardless of insurance coverage.

________ (INITIALS)

I also understand that I will be charged for all collections costs and reasonable attorney fees. (Note: 25% collection fee added to account balance) ________ (INITIALS)

***WORKMANS' COMPENSATION SECTION* AUTHORIZATION TO RELEASE INFORMATION TO EMPLOYER & INSURANCE CARRIER**

I hereby authorize Function1st Physical Therapy, LLC to release any information acquired in the course of my evaluation and/or treatment. ________ (INITIALS)

I hereby agree to personally accept responsibility for the payment of any fees that are incurred as a result of treatment if this injury is disputed as not being a work injury claim for any reason. (Note: Payment is considered past due 60 days of treatment date and is subject to a 12% annual interest charge. ________ (INITIALS)

I hereby acknowledge that I've read, understood and completed the above information to the best of my knowledge.

Signature ______________________________________ **Date** __________________