

The Physical Medicine and Rehabilitation Center P.A.

Registration

Date _____

Last Name		First Name		Middle Init	Sex
Address			City	State	Zip
Home Tel		Bus Tel		No. of Children	
Date of Birth	Age	SS#		Children's Age(s)	
Email					
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)		Live <input type="checkbox"/> Alone <input type="checkbox"/> With		No. of stairs inside	No. of stairs outside
Employer Name				Occupation	
Emp. Address				Emp. Tel	
Referred By					
Referring Physician				Telephone	
Family Physician				Telephone	
Next of kin		Relationship		Telephone	
Social History					
Packs of cigarettes / day		Use of recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No		# of alcoholic drinks per week	
Past Medical History					
<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Ulcer <input type="checkbox"/> Heartburn <input type="checkbox"/> Heart disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Asthma <input type="checkbox"/> Lung Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Other _____					
Surgeries (dates)					
Current medications				Allergies to medication	
<input type="checkbox"/> Right handed		<input type="checkbox"/> Left handed		Height	Weight
Physical Demands at:		Work		Exercise	
Sports		Hobbies		Other:	
Did you have physical/occupational therapy elsewhere this calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what condition? _____ At which facility? _____					
Do you have home nursing, a home health aide or home therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Family history: Are there any immediate family members with the following: <input type="checkbox"/> Neurological disorder <input type="checkbox"/> Heart disease <input type="checkbox"/> Back problems <input type="checkbox"/> Cancer <input type="checkbox"/> Neck problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Joint problems					

MD Signature _____ Date _____

ACCIDENT INFORMATION _____ REHAB RN _____ Telephone# _____

MVA Workers' Compensation Date of Accident _____

Name of Insurance Company: _____

Adjuster: _____ Phone #: _____

Claim #: _____

Employer at time of injury: _____

Attorney's Name: _____ Attorney's Phone #: _____

Attorney's Address: _____

Have you filled out & returned your PIP application? Yes No Has your employer filed an accident report? Yes No

Insured's name if not the same: _____

Address _____
Street City State Zip Code

Telephone _____ Business Telephone _____

Patient's relationship to insured: Self Spouse Child Other _____

Medicare? Yes No If Yes: Number _____ Eff. Date _____ Part A Part B

If you are a Medicare patient, have you had therapy anywhere else since January 1, 1999? Yes No

If yes, name of facility: _____ Location of facility _____

Insured Individual or Spouse Information: Name _____

Relationship to patient: _____ SS# _____ Date of Birth _____ Telephone _____

Primary Insurance _____

Policy # _____ Group # _____

Address _____ Telephone # _____

Secondary Insurance _____

Policy # _____ Group # _____

Address _____ Telephone # _____

Assignment of Benefits (Medicare/Private Patients):

I authorize payment of medical benefits directly to The Physical Medicine & Rehabilitation Center, P.A., for service described. I accept full responsibility for total amount of bill.

Signature _____ Date _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administrations or their intermediaries or carries, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment,

Signature _____ Date _____

FOR YOUR INFORMATION: Your appointment is reserved exclusively for you. Please be on time for your appointments. As a courtesy to those patients waiting for appointments, 24 hour notice is required to cancel your appointment. Failure to adhere to this policy may result in a \$50.00 charge.

PRIVATE INSURANCE: If provided with your insurance information and a copy of your insurance card, we will process the claim for you and provide all the necessary paperwork to accompany your claim. If your insurance company is slow to pay or denies the claim, it your responsibility to follow up with them. **HOWEVER, YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT AND ANY DEDUCTIBLE AT THE TIME OF SERVICE AND/OR ANY REMAINING BALANCE NOT COVERED BY YOUR INSURANCE,**

MEDICARE: We will submit your claim to Medicare. We accept Medicare assignment; therefore payment will come directly to us However, you are still responsible for the 20% co-pay of what Medicare approves. If you have a secondary insurer, please be sure to provide us with a copy of your insurance card so we can submit to your secondary carrier

NO-FAULT INSURANCE: If your claim was verified prior to your appointment, we will submit the bill to your insurance carrier in lieu of payment at time of service. We expect you to promptly complete and mail to your insurance carrier your PIP form and any other necessary paperwork needed by the carrier to process your claim **YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLE AND CO-PAYMENT.** If you have a secondary insurance to cover this balance, it is up to you to file the claim.

WORKER'S COMPENSATION: If you are being seen due to a work related injury, we will file with your compensation carrier- We expect you to provide us with the complete information to properly process your claim- If the insurance carrier denies the claim, you are responsible for the outstanding balance.

SIGNED _____ Date _____

Date _____/_____/_____

Name: _____

Review of Systems		Circle One	Circle One		Circle One	Circle One
Physical Medicine and Rehabilitation Center						
<u>CONSTITUTIONAL</u>				<u>GENITOURINARY</u>		
Do you have fevers, sweats or chills?	Yes No			How many times a night do you urinate? _____		
Do you have trouble with your appetite?	Yes No			Do you have trouble stopping or starting urinating?	Yes No	
Have you had more than a 10 lb. change in weight in the last year?	Yes No			Do you ever lose your urine accidentally?	Yes No	
Do you frequently feel tired?	Yes No			<u>WOMEN WITH MENSTRUAL PERIODS</u>		
<u>SKIN</u>				Date last menstrual period began _____	Yes No	
Do you have any skin rashes, sores or itching?	Yes No			Do you have any vaginal bleeding between periods or after intercourse?	Yes No	
Do you have any moles or beauty marks that are changing or troubling you?	Yes No			<u>WOMEN WITHOUT MENSTRUAL PERIOD</u>		
<u>EYES, EARS, NOSE AND THROAT</u>				Age at last menses: _____		
Do you have eye problems or trouble with your vision?	Yes No			Are you bothered by hot flashes?	Yes No	
Do you have any ear problems or trouble with your hearing?	Yes No			Do you ever have bleeding/spotting?	Yes No	
<u>RESPIRATORY</u>				<u>ALL WOMEN</u>		
Do you have a persistent cough or phlegm?	Yes No			Do you have any lumps, discharge, or pain in your breasts?	Yes No	
Do you have any wheezing?	Yes No			<u>MEN</u>		
<u>CARDIAC</u>				Do you have any discharge from your penis?	Yes No	
Do you have trouble breathing?	Yes No			<u>NEUROLOGIC</u>		
Do you have pain or tightness in your chest?	Yes No			Are you bothered by frequent headaches?	Yes No	
Have you had a cardiac stress test? Date _____	Yes No			Do you have fainting or falling out spells?	Yes No	
Reason for cardiac stress test: _____	Yes No			Do you fall or have trouble with your balance?	Yes No	
Results of cardiac stress test: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____	Yes No			Do you have any numbness, tingling or weakness in your arms or legs?	Yes No	
Have you had an abnormal EKG?	Yes No			Have you had any serious trouble with your memory?	Yes No	
Have you had palpitations?	Yes No			Have you had strokes, seizures or epilepsy?	Yes No	
Have you had dizziness, light headedness or faintness?	Yes No			Do you snore?	Yes No	
Have you had a heart attack?	Yes No			Do you experience daytime drowsiness?	Yes No	
Have you had heart disease or any heart condition?	Yes No			Do you gasp for breaths at night?	Yes No	
Do you have high blood pressure?	Yes No			Do you have trouble falling asleep?	Yes No	
Do you have high cholesterol?	Yes No			<u>HEMATOLOGIC</u>		
Do your ankles swell?	Yes No			Do you have a low blood count?	Yes No	
<u>GASTROINTESTINAL</u>				Do you bruise or bleed easily?	Yes No	
Do you have any difficulty swallowing?	Yes No			<u>ALLERGIC/IMMUNOLOGIC</u>		
Do you have any stomach pains, heartburn or vomiting?	Yes No			Do you have any allergies?	Yes No	
Do you have constipation or use laxatives often?	Yes No			Do you have any swollen glands?	Yes No	
Do you have frequent diarrhea?	Yes No			<u>PSYCHIATRIC</u>		
Have you had any black or bloody bowel movements?	Yes No			Do you often feel depressed or sad?	Yes No	
Has there been any change in the color, size or consistency of your bowel movements recently?	Yes No			Are you upset or nervous more than you feel you should be?	Yes No	
<u>OSTEOPOROSIS</u>				Do you have trouble sleeping?	Yes No	
Have you had bone density testing? Date _____	Yes No			<u>SPORTS PERFORMANCE</u>	Yes No	
Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				Do you play sports?	Yes No	
				Do stress, anxiety, or frustration affect your athletic performance?	Yes No	

MD Signature _____ Date _____

Date ____/____/____

Name: _____

Activities of Daily Living

Do you have difficulty performing any of the following or pain when performing any of the following?

	No Problem	Able with Pain (describe)	Difficulty (describe)
Sitting			
Arising			
Driving			
Exercise			
Walking			
Stairs			
Cooking			
Grooming			
Dressing			
Feeding			
Other			

IF YOU HAVE PAIN, PLEASE FILL IN THE FOLLOWING:

Please indicate here on this line your overall level of pain is:

No pain at all ----- Pain too excruciating to bear

Shade in areas of pain

