ProRehab

Patient Registration Form

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ SS number: _____ Date of birth: _____

Please check all the ways we can contact you

☐ Home phone: _____ ☐ Cell phone: _____ ☐ SMS/Text on cell

☐ E-mail address: _____ ☐ Work phone: _____

Please keep in mind that communications via email over the internet is not a secure form of communication.

Employer and Employer phone number: _____

Who is your General Physician: _____

2nd contact person name/address: _____

Phone Number: _____ Relation: _____

Please Fill Out The Following Information If Different From Above

Primary

Policy holder information: _____
(name, address, Insurance plan name)

Policy holder DOB: _____ ID/SS#: _____ Group number: _____

Secondary

Policy holder information: _____
(name, address, Insurance plan name)

Policy holder DOB: _____ ID/SS#: _____ Group number: _____

Is this work related? Yes No **If yes**, Date of Injury: _____

Employer address:_____

Is this Motor Vehicle Accident related? Yes No **If yes**, State _____ and Date of accident: _____

How did you hear about us? ☐ Physician Referral, who referred _____ ☐ Family or Friend

☐ Industry ☐ Advertisement (please list) _____ ☐ Other (please list) _____

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at ProRehab and/or as directed by my referring physician.

I assign medical benefits payable for these services directly to ProRehab. I authorize the release of any medical or other information necessary to process claims for these services.

I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service. In Medicare assigned cases, ProRehab participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services.

In signing this form I acknowledge that I am responsible for the bill not paid by the insurance carrier.

I understand that my health information will be used for treatment, payment and healthcare operations, (see the Notice of Privacy Practice).

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

_____ _____

Patient/Legal Guardian Signature Date

Relationship to Patient: _____

_____ I acknowledge receipt of the Notice of Privacy Practices which provides information on how my Protected Health Information may

Initial be used or disclosed, if I have any questions I can contact the Compliance Department.

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MEDICAL HISTORY AND PREVIOUS TREATMENT FORM

PATIENT NAME: _____ Acct#: _____

Please check if you have been diagnosed with any of the following conditions:

_____Diabetes(I/II)	_____Heart Disease	_____High Blood Pressure	_____Cancer
_____Pacemaker	_____Stroke (TIA or CVA)	_____Seizures	_____Metal Implants
_____Back Pain	_____Circulation problems	_____Osteoporosis	_____Stomach ulcers
_____Broken bones	_____Respiratory Problems	_____Depression	
_____Blood Clots	_____Rheumatoid Arthritis	_____Thyroid Problems	

_____Infectious Diseases (HIV, Hepatitis B, Hepatitis C, TB, etc.) _____

_____Other: _____

Surgical History: _____

During the past month have you been feeling down, depressed, or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Please list all medications you are currently taking (prescribed and over the counter):_____

_____

_____

Have you recently noted?

YES	NO	Weight loss/gain	YES	NO	Nausea/Vomiting
YES	NO	Dizziness/Lightheadedness	YES	NO	Unusual weakness
YES	NO	Fever/chills/sweats	YES	NO	Visual problems
YES	NO	Incontinence	YES	NO	Hearing problems
YES	NO	Bleeding	YES	NO	Pregnant or think you might be pregnant

Date of onset of current symptoms/injury: Month _____ **Day** _____ **Year** _____

Have you had the same or a similar problem in the past? YES NO
If yes, please explain: _____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc._____

Have you received X-rays, MRI, CT scan, Bone Scan, etc for this problem? _____

Has your doctor discussed your medical findings or given you a diagnosis? YES NO
If yes, what were the findings? _____

Do you require this therapy to return to prior level of function? YES NO

What are your goals for recovery? _____

Are you aware of any physical reason why you should not receive treatment? YES NO
If yes, please tell us what it is: _____

Do you have any allergies? YES NO If yes, please list: _____

To the best of my knowledge the above information is accurate and complete

Signature: _____ **Date:** _____

Thank you for completing this questionnaire. It will allow us to better serve your needs.

Therapist signature: _____ Date: _____