JONES Physical Therapy

# 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: _____

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## How did you get hurt?

Please read the through the situations below carefully. If none apply to you, initial here _____ and proceed to the next page.

### Worker's Compensation

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: _____Date of Injury:_____

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

### Motor Vehicle Accident

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

### At School

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: _____

_____

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## Patient Medical History

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

Please provide your current Height: _____ft _____in Weight: _____lbs

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 _____

**Allergies:** (Check all that apply)

_____ NSAIDs _____ Cocoa Butter _____ Latex _____ Adhesives Other: _____

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

_____ X-Ray _____ 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 _____

**If you checked any of the options above, when were you last treated?**_____

Have you been a patient of Jones Physical Therapy in the past? ❑ Yes ❑ No

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

Prescription: _____

Non-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 | _____ COVID (Past 2 weeks) | |

Other (please specify) _____

**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.*