Blum Physical Therapy

REGISTRATION

Date _____

PATIENT INFORMATION

Patient Name _____ SS# _____ DOB ____/____/_____

Address _____ Age _____

Home Phone _____ Cell Phone _____ E-Mail _____

Place of Employment _____ Phone _____

Employment Address _____

Person Responsible for Payment _____ Relationship to patient_____

Address _____ Phone _____

EMERGENCY NOTIFICATION

Name_____ Relationship _____

Home Phone _____ Cell Phone _____

Address _____

INSURANCE INFORMATION

(Please provide us with a copy of your insurance card)

Primary Insurance _____

Policy Holder

Name _____

DOB _____ SSN _____

Relationship to patient _____

Employer_____

Secondary Insurance _____

Policy Holder

Name _____

DOB _____ SSN _____

Relationship to patient _____

Employer _____

OTHER INFORMATION

Referring Physician _____ Date Last Seen _____

Familiy Physician _____ Date Last Seen _____

Is this injury the result of an accident? Yes / No Auto / Work / Other

Date of Injury _____ Date of Surgery _____

Have you received Physical Therapy, Occupational Therapy, or Speech Therapy in the last year? Yes/No

Blum Physical Therapy

Policy Acknowledgement and Signature Page

Acknowledgement of the HIPPA Privacy Notice

By signing below I acknowledge that I was offered the opportunity to review Blum Physical Therapy's HIPPA Privacy Notice.

__ I would like to have a copy of this office's HIPPA Privacy Notice.
__ I would not like to have a copy of this office's HIPPA Privacy Notice.
__ I refuse to sign because_____

The following persons listed are allowed to obtain treatment information and/or billing information associated with my treatment at Blum Physical Therapy.

Spouse: Yes No Name: _____ Parent: Yes No Name: _____

Employer: Yes No Name: _____ Child: Yes No Name:_____

Other: Yes No Name: _____

If I am unable to be reached, I give my permission to have messages regarding my appointment time, changes of, or scheduling information left as follows:

____ on voice mail ____ with family member ____ at work

CONSENT TO TREATMENT: I hearby authorize the healthcare providers of Blum Physical Therapy to administer such treatments, as they deem necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

FINANCIAL RESPONSIBILITY: I agree that I am financially responsible for all charges relating to services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree it is my responsibliity to obtain prior approval required by my insurance and to take all other steps to qualify for insurance coverage. Balance of bill payment is due within 30 days of final payment by insurance company.

CO-PAYMENTS ARE DUE AND PAYABLE ON THE DATE OF SERVICE: We accept cash and check. A $15 charge will be applied for returned checks.

ASSIGNMENTS OF BENEFITS: I hearby assign to Blum Physical Therapy all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to Blum Physical Therapy.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if patient is under 18)

Relationship to patient _____

Blum Physical Therapy

MEDICAL HISTORY FORM

Date _____

Name _____ **DOB** _____

Do you now or have you ever had any of the following conditions? (check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac conditions
- ☐ Cardiac pacemaker
- ☐ Chemical dependency
- ☐ Circulation problems
- ☐ Currently pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy spells
- ☐ Emphysema/bronchitis
- ☐ Fractures
- ☐ Gallbladder problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Incontinence
- ☐ Kidney problems
- ☐ Metal implants
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Vision Problems

Describe any other conditions or precautions:

Falls History

Have you had an injury as a result of a fall in the past year? Yes No Date of Fall _____

Have you had two or more falls in the last year? Yes No Dates of Falls _____

Surgical History

Surgery _____ Date_____

Surgery _____ Date_____

Surgery _____ Date_____

Surgery _____ Date_____

Surgery _____ Date_____

Current Medications

☐ I have a list of my medications with me *(if you have a written list you do not need to fill out this section)*

Medication_____ Dose _____ Reason for Taking _____

Medication_____ Dose _____ Reason for Taking _____

Medication_____ Dose _____ Reason for Taking _____

Medication_____ Dose _____ Reason for Taking _____

Medication_____ Dose _____ Reason for Taking _____

Medication_____ Dose _____ Reason for Taking _____

Medication_____ Dose _____ Reason for Taking _____