CUTTING EDGE
physical therapy and rehabilitation

Patient Registration Form

Personal Information

Name:		Name you prefer:
Home Address:		Apt #
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Injury/ Diagnosis:		Home Phone:
Date of Injury/Onset of symptoms:		Work Phone:
Date of Birth:	Age:	Cell Phone:
Email Address:		
Emergency Contact:		Emergency Contact Phone #:
How did you hear about us?:		

Referring Physician Name:		Phone #:
City, State:		
Primary Care Physician Name:		Phone #:
City, State:		
Employer Name:		Occupation:
Address:		City, State:
Social Security Number (For Insurance Benefit Verification):		

Primary Insurance Information

Is this an auto accident?:	Yes	No	Is this a worker's comp case?:	Yes	No
If "Yes", list claim # and adjuster contact information:					
Health Insurance Company Name:					
Subscriber's Name:			Subscriber's Date of Birth:		
Relationship to the Subscriber:					
Subscriber's Address and Phone # if different from patient:					
Address:					
City, State		Zip		Phone#	

Secondary Health Insurance Information

Health Insurance Company Name:		
Subscriber's Name:	Subscriber's Date of Birth:	
Relationship to the Subscriber:		
Subscriber's Address and Phone # if different from patient:		
Address:		
City, State	Zip	Phone#

Consent to Treatment

I hereby authorize the professional staff at Cutting Edge Physical Therapy and Rehabilitation to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Notice of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Cutting Edge Physical Therapy and Rehabilitation has offered me a copy of their Notice of Privacy Practices for my own records.

If there is anyone you would like to authorize the disclosure of your PHI, medical or billing, you may specifically name the party below and indicate what information you would like to disclose:

1. _____ ☐entire medical record ☐diagnosis & medical treatment ONLY ☐billing ONLY

2. _____ ☐entire medical record ☐diagnosis & medical treatment ONLY ☐billing ONLY

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Staff Witness Initials:_____

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Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable) _____

2. Do you now or have you ever had the following?

		Explain
Stroke	*yes* _____ *no* _____	_____
Heart Disease or Heart Murmur	*yes* _____ *no* _____	_____
High Blood Pressure	*yes* _____ *no* _____	_____
Asthma	*yes* _____ *no* _____	_____
Diabetes	*yes* _____ *no* _____	_____
Epilepsy/Fainting	*yes* _____ *no* _____	_____
Impairment of Vision or Hearing	*yes* _____ *no* _____	_____
Cancer	*yes* _____ *no* _____	_____
Drug Allergies	*yes* _____ *no* _____	_____
Osteoporosis	*yes* _____ *no* _____	_____

Orthopaedic History – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

   Neck/Head (including concussion) _____

   Trunk (ribs, vertebrae, sternum) _____

   Low Back (vertebrae, discs, nerves) _____

   Upper Extremity (shoulder, elbow, wrist, arm) _____

   Lower Extremity (hip, leg, knee, ankle, foot) _____

4. Please list any surgeries that you have had and their dates:
   _____

5. Please list medication(s) presently taking: _____

6. Women: Are you pregnant? yes _____ no _____

7. Have you ever had PT in the past?_____
   If so, when? _____

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?**_____

9. If so, what is the **name and phone number** to the agency? _____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature_____date:_____

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Missed Appointment Policy

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *Cutting Edge Physical Therapy and Rehabilitation* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please note that we require a **24-hour notice**.

If you need to cancel please call our office and reschedule. If you do not cancel with a **24-hour notice** or if you do not show for an appointment **you will be charged $65** for the missed appointment.

If you miss **3** consecutive appointments we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *Cutting Edge Physical Therapy and Rehabilitation* and we are looking forward to working with you and helping you reach your goals.

The Staff at Cutting Edge Physical Therapy and Rehabilitation

I have read and understand this policy.

_____ _____

Patient/ Guardian Date