

Palos Verdes Physical Therapy

Patient Registration Form

Date: _____

Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>				Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>					
<input type="checkbox"/> New Patient		<input type="checkbox"/> Re-Start		<input type="checkbox"/> New Diagnosis		<input type="checkbox"/> New Insurance		PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient #	Title	Patient Name (Last, First, Middle Initial)							
Address						City/State/Zip			
Home Phone ()			Work Phone ()			Email Address			
Social Security #		DOB		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License #		Financial Class	
Referring Physician				UPIN		Referring Physician Phone#		Treating Therapist	
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA		Primary location CLINIC		Marital Status		Student		Employment Status	
Occupation				Employer				Employer Phone #	
Address						City/State/Zip			

Emergency Contact (Name)			Home Phone ()			Work Phone ()		
Address			City/State/Zip			Relationship to Patient		

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)				Relationship to Patient			
Address				City/State/Zip			
Home Phone ()		Work Phone ()		Email Address			
Social Security #		DOB		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License #	

Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Surgery		Surgical Procedure			
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident			
Describe Accident							
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury			Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No		
Name of employer at time of accident				City, State, Zip Code			
Describe Injury							
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Attorney			Phone # ()		

-Office Use Only-

Diagnosis:				ICD-9 Code:			
Diagnosis:				ICD-9 Code:			
Diagnosis:				ICD-9 Code:			

Insurance Information

Were benefits and authorization verified? Yes No

Primary Insurance		In- network <input type="checkbox"/> Out-of-network <input type="checkbox"/>		Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		Visits per Year	
Claims Mailing Address			City, State, Zip Code				
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship to Patient		
ID Card #(including alpha prefix)		Group #		Authorization #			
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty \$		Visits Remaining	
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()				
Benefits Verified By		Date	Spoke to			Ins. Customer Service Phone # ()	

Secondary Insurance		In- network <input type="checkbox"/> Out-of-network <input type="checkbox"/>					
Claims Mailing Address			City, State, Zip Code				
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship to Patient		
ID Card #(including alpha prefix)		Group #		Authorization #			
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year	
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()				
Benefits Verified By		Date	Spoke to			Ins. Customer Service Phone # ()	

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by Palos Verdes Physical Therapy and assigns to Palos Verdes Physical Therapy any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes Palos Verdes Physical Therapy to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or Palos Verdes Physical Therapy for payment of charges to the patient.
4. Palos Verdes Physical Therapy reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for Palos Verdes Physical Therapy.

Patient Signature:	Date:
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<i>CPM Office Use Only:</i>	<i>Entered by:</i>	<i>Date:</i>
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Patient Health Questionnaire

Patient Name _____

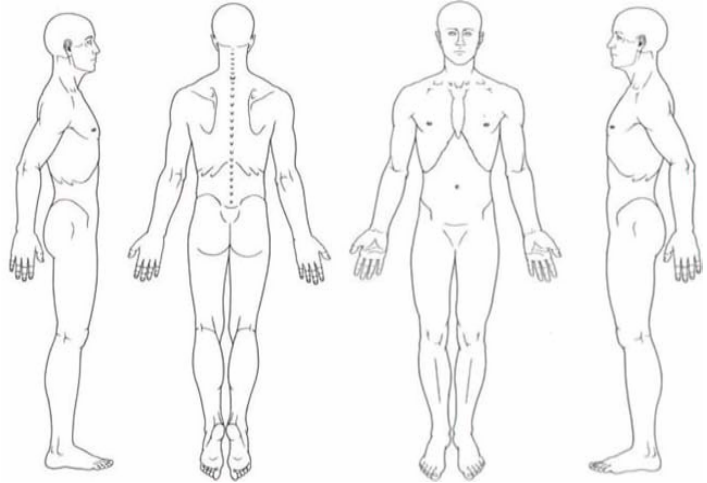
Date _____

1. Describe your symptoms _____

- a. When did your symptoms start? _____
- b. How did your symptoms begin? _____

**2. How often do you experience your symptoms?
 Indicate where you have pain on the chart below:**

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What best describes the nature of your symptoms?

- ① Sharp ② Shooting
- ③ Dull Ache ④ Burning
- ⑤ Numb ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

- a. Indicate where you have pain or other symptoms
 - b. How much has pain interfered with your normal work (including both work outside the home and housework)
- None.....Unbearable
 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

- (like visiting with friends, relatives, etc)
- ① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One ③ Medical Doctor ⑤ Other
- ② Chiropractor ④ Physical Therapist

- a. What treatment did you receive and when? _____
 - b. What tests have you had for your symptoms and when were they performed?
- ① Xrays date: _____ ③ CT Scan date: _____
 ② MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes ② No
 - a. If you have received treatment in the past for the same or similar symptoms, who did you see?
- ① This office ③ Medical Doctor ⑤ Other
 - ② Chiropractor ④ Physical Therapist

10. What is your occupation?

- ① Professional/Executive ④ Laborer ⑦ Retired
- ② White Collar/Secretarial ⑤ Homemaker ⑧ Other
- ③ Tradesperson ⑥ FT Student

- a. If you are not retired, a homemaker, or a student, what is your current work status?
- ① Full-time ③ Self-employed ⑤ Off work
 - ② Part-time ④ Unemployed ⑥ Other

Patient Signature _____

Date _____

11. Are you currently experiencing or have you ever experienced any of the following? Please mark below

Diabetes	yes () no ()	Kidney Problems	yes () no ()
High Blood Pressure	yes () no ()	Nervous disorders	yes () no ()
Heart Disease	yes () no ()	Pregnant / IUD	yes () no ()
Heart Attack	yes () no ()	Allergies / Skin	yes () no ()
Pacemaker	yes () no ()	Hernia	yes () no ()
Headaches	yes () no ()	Metal Implants	yes () no ()
Dizziness	yes () no ()	Shortness of Breath	yes () no ()
Cancer	yes () no ()	Asthma	yes () no ()
Seizure	yes () no ()	Heart Murmur/Arrhythmia	yes () no ()
Any previous injury	yes () no ()	Stroke	yes () no ()
Injured in a Motor Vehicle Accident	yes () no ()	Previous Surgery	yes () no ()

IF YES on any of the above please give details & approximate dates _____

12. Are you currently taking MEDICATIONS? Yes / No Please List: _____

13. What makes the pain WORSE? (√ All that Apply)

lying down sitting standing walking other _____

14. Are What EASES the pain? (√ All that Apply)

lying down sitting standing walking other _____

15. List the activities are you having difficulty doing (at home, work, & recreationally)?

Thank you. This information will assist your Physical Therapist with your treatment.