Patient Registration Form

Patient Information

Last Name _____ First Name _____ MI _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Date of Birth _____ Email _____

Primary MD _____ MD Phone _____

Would you like an appointment reminder?
☐No ☐ Email ☐ Text message ☐Phone call ☐ home ☐ cell ☐work

How did you first hear about us? ☐ My doctor ☐ Friend/Family ☐ Our website ☐ Internet Search ☐ Yelp
☐Other Online Directory (Angies' List, YP, CitySearch, etc.) ☐ Facebook ☐ Twitter ☐ Other: _____

Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone _____

Insurance Information

Primary Insurance _____ Group# _____ ID# _____

Subscriber name _____ Subscriber DOB _____ Relationship to Patient _____

Secondary Insurance _____ Group# _____ ID# _____

Subscriber name _____ Subscriber DOB _____ Relationship to Patient _____

Policies and Procedures

Uses and Disclosures of Health Information. PrimeTrack Wellness and Rehabilitation may use and disclose my personal health information for treatment, obtaining payment, and healthcare operations.

Assignment of Benefits I hereby assign medical benefits, including major medical, private insurance, and any other health plans to PrimeTrack Wellness and Rehabilitation. This assignment will remain in effect until revoked by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Financial Policy. I understand that

- PrimeTrack Welllness and Rehabilitation will submit all billing to my insurance as a courtesy to me;
- payment including co-payments & co-insurances are due at the time services are rendered;
- if I have a deductible, I am responsible for all charges until the deductible is met;
- all Workers' Compensation and motor vehicle injuries must be verified for eligibility;
- any money paid to me by my insurance company for services billed and rendered by PrimeTrack Wellness and Rehabilitation shall be paid to PrimeTrack Wellness and Rehabilitation immediately upon receipt. Failure to do so is illegal;
- it is my responsibility to notify the office of any patient information changes, including address, name, insurance information, etc.;
- verification of insurance benefits does not guarantee payment. Should my insurance fail to pay, for any reason, I am responsible for the balance.

By signing below, I acknowledge that I have read, understood, and agreed to the terms and conditions as outlined on this form.
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature _____ Date _____

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Feeling better every day

Patient Intake Form

Name: _____ Acct #: _____ Today's Date: _____
Date of Birth: _____ Primary Care Physician: _____
Date of last Physical: _____ Date of Last x-ray : _____ Date of last MRI: _____

Please answer the following:	Y	N	Date		Y	N	Date
Are you currently under a doctor's care?	◯	◯		Do you have a pacemaker?	◯	◯	
Have you had any surgeries?	◯	◯		Have you ever had an aneurysm?	◯	◯	
Have you ever been diagnosed with cancer or had any tumors?	◯	◯		Do you have any pins, plates or other surgical implants?	◯	◯	
Are you pregnant?	◯	◯		Do you have any cracked or broken bones?	◯	◯	

Please answer the following:	Y	N	Date		Y	N	Date
Do you have an artificial limb or joint?	◯	◯		Do you have epilepsy or get seizures?	◯	◯	
Have you ever been diagnosed with a Deep Vein Thrombosis (DVT)?	◯	◯		Have you been diagnosed with a disc herniation?	◯	◯	
Have you ever had a heart attack?	◯	◯		Do you have any bleeding or clotting problems?	◯	◯	
Do you get severe migraines?	◯	◯					

Please answer the following:	Y	N	Date		Y	N	Date
Do you have High blood pressure?	◯	◯		Any recent injuries?	◯	◯	
Do you get tingling or numbness into hands and feet?	◯	◯		Do you have arthritis?	◯	◯	
Do you have varicose veins?	◯	◯		Any recent cuts or stitches?	◯	◯	
Do your feet or hands always feel cold?	◯	◯		Have you had a hernia?	◯	◯	
Do you have any surface piercings or other fragments?	◯	◯		Do you use an IUD?	◯	◯	
Have you had any recent infections?	◯	◯					

List Allergies

List Medications

Notes:

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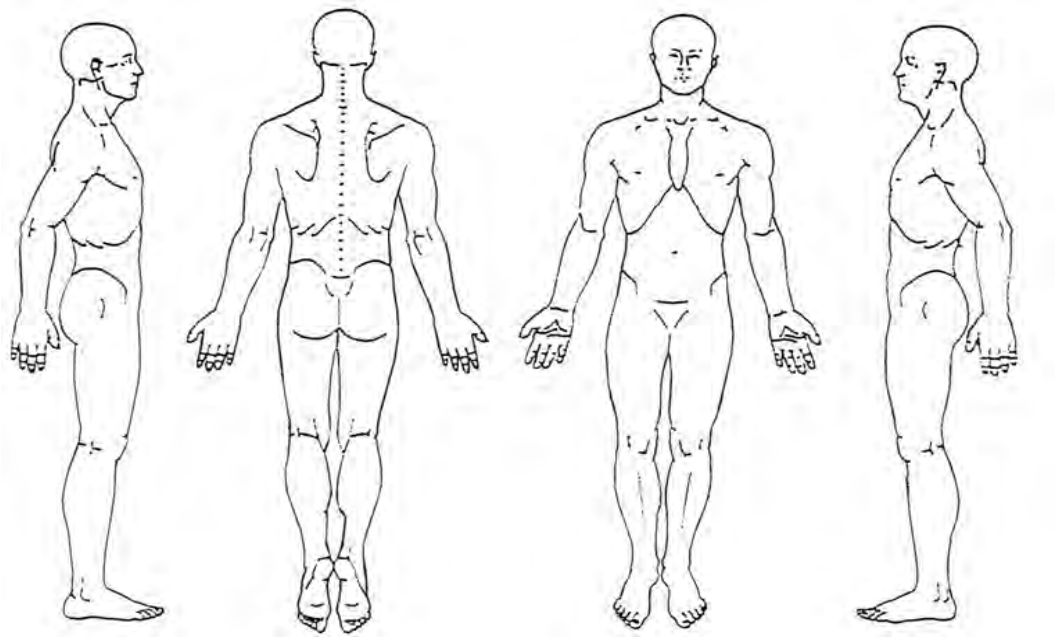
Patient Pain Record

Acct #: _____ Name: _____ Date: _____

Problem areas: *Use scale below to mark on the diagram the type of pain you are experiencing. Use 1 symbol for mild pain, 2 symbols for moderate pain and 3 symbols for severe pain.*

D - Dull pain	N - Numb	S - Stabbing/cutting
T - Tingling	B - Burning	C - Cramping



Please Mark on the line below to indicate your pain level when at WORST:

No Pain ○○○○○○○○○○○○○○○○○○○○○ **Worst Pain**

0 2 4 6 8 10

Please rate the following regarding health habits:

	None	Little	Moderate	A lot
Exercise	○	○	○	○
Sleep	○	○	○	○
Alcohol use	○	○	○	○
Tobacco use	○	○	○	○
Drug use	○	○	○	○

Have you been diagnosed with any illness? (i.e. High cholesterol, etc.) ☐ Yes ☐ No

If yes, please specify:

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by PrimeTrack Wellness and Rehabilitation for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of PrimeTrack Wellness and Rehabilitation. I understand that analysis, diagnosis or treatment of me by PrimeTrack Wellness and Rehabilitaion may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. PrimeTrack Wellness and Rehabilitation is not required to agree to the restrictions that I may request. However, if PrimeTrack Wellness and Rehabilitation agrees to a restriction that I request, the restriction is binding on PrimeTrack Wellness and Rehabilitation. I have the right to revoke this consent, in writing, at any time, except to the extent that PrimeTrack Wellnes and Rehabilitaion has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of PrimeTrack Wellness and Rehabilitation and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of PrimeTrack Wellness and Rehabilitation. The Notice of Privacy Practices is also available upon request from PrimeTrack Wellness and Rehabilitation. This Notice of Privacy Practices also describes my rights and duties of PrimeTrack Wellness and Rehabilitation with respect to my protected health information.

PrimeTrack Wellness and Rehabilitation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling PrimeTrack Wellness and Rehabilitation and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
Printed Name of Patient	Printed Name of Legal Guardian

