Pinnacle Medical Group Patient Registration Form

PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_____ (First)_____ (MI) _____

Previous Name (Last) _____ (First) _____

Address_____City_____ State_____ Zip _____

Home Phone_____ Cell_____ Work_____ Ext. _____

Primary Care Provider (PCP)_____ Referring Provider _____

Email Address _____

Date of Birth _____/_____/_____ ☐ Female ☐ Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black or African American ☐ White ☐ Decline

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Japanese ☐ Chinese ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security No. _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full Time ☐ 2 - Part Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full Time Student ☐ P - Part Time Student ☐ N - Not a Student Do you have a living will? ☐ Yes ☐ No

Emergency Contact Name_____ Phone Number _____

Emergency Contact Relationship to Patient _____ ☐ Guardian

Home Phone_____ Cell_____ Work_____ Ext. _____

RESPONSIBLE PARTY INFORMATION

(Information used for patient balance statements)

Responsible Party ☐ Guarantor ☐ Self

Responsible Party Name (Last)_____ (First)_____ (MI) _____

Also Known As Name (Last) _____ (First) _____

Date of Birth _____/_____/_____ ☐ Female ☐ Male Social Security No. _____-_____-_____

Home Phone_____ Cell_____ Work_____ Ext. _____

Address_____City_____ State_____ Zip _____

Employer_____ Employer Phone _____

PRIMARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at check-in)

Insurance Company _____ Insurance Company Phone _____

Name of Insured_____ Patient Relationship to Insured _____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____/_____/_____ Termination Date_____/_____/_____ Date of Birth _____/_____/_____

SECONDARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at check-in)

Insurance Company _____ Insurance Company Phone _____

Name of Insured_____ Patient Relationship to Insured _____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____/_____/_____ Termination Date_____/_____/_____ Date of Birth _____/_____/_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ **Date**_____/_____/_____

Pinnacle
MEDICAL GROUP
THERAPY AND WELLNESS CENTER

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Reason for Therapy: _____ **Date of Onset:** _____

Please report any previous therapy including place and dates: _____

_____

_____

_____

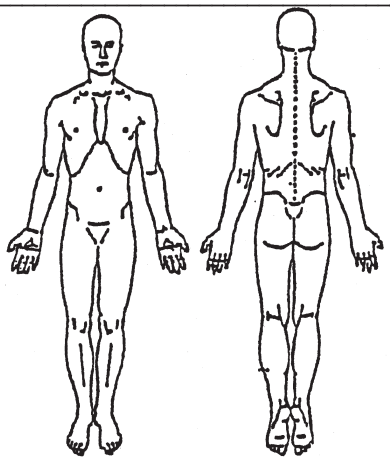
_____

_____

Please describe your pain scale. "0" is no pain "10" is Worst possible pain

Today: _____ Worst in last 30 days _____ Least in last 30 days _____

Please "X" the area of your problem in the diagram



Please list any X-Rays, MRIs, or testing you have done, including date if possible:_____

_____

Please list any medications you are taking:_____

_____

Is this service for treatment related to a work injury? ◯ Yes ◯ No

Is this service for treatment related to a motor vehicle accident? ◯ Yes ◯ No

Medicare will not pay for concurrent home health and outpatient therapy services.

Are you currently receiving home health services? ◯ Yes ◯ No If yes, Name of Agency:_____

Home Health Agency Phone Number:_____

Have you been discharged from home health within the last 30 days? ◯ Yes ◯ No

Home health start date:_____ **Home health discharge date:**_____

Please circle any medical conditions you have:

Allergies	Arthritis	Asthma	Cancer	Chest pain	Chronic bronchitis	Diabetes
Dizziness	Emphysema	Heart disease	Heart attack	Hepatitis	High blood pressure	Hypoglycemia
IBS	Kidney problems	Liver disease	Parkinson's	Pneumonia	Polio	Rheumatic Fever
Ringing in Ears	Shortness of breath	Stroke	Ulcers	Urinary tract Infection	Pregnancy	

Other _____