PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)____________________________________ (First)_________________________________ (MI) __________

Preferred Full Name (if different from above): ________________________________

Home Phone Number (landline):__________________________ Cell:_________________________ Work: _______________________

Address: ____

City, State, Zip: ____

Email Address:____ Date of Birth: ___________________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer
☐ Choose not to disclose   Additional Gender Category not listed ______________________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Choose not to disclose ☐ Other not listed __________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Swahili ☐ Portuguese ☐ Arabic
☐ Indian: Hindi, Tamil, Gujarati etc ☐ Russian ☐ Vietnamese ☐ Haitian ☐ Albanian ☐ Burmese ☐ Cambodian
☐ Creole Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Other not listed____________

Patient Social Security Number:______-______-_______

RESPONSIBLE PARTY INFORMATION *(If not self)*

(Information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self   Check here is address and telephone information is same as patient ☐

Responsible Party Name: (Last)___________________________________ (First)________________________________ (MI) _______

Date of Birth: MM_____/ DD_____/ YYYY_________   Sex: ☐ Female ☐ Male

Address: ____

City, State, Zip: ____

Responsible Party Social Security Number:______-______-_______   Phone Number:_____________________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last)__________________________________ (First)_______________________________________

Phone Number:____ Do you have a living will: ☐ Yes ☐ No

Emergency contact relationship to patient: ____ ☐ Guardian

Address: ____

City, State, Zip: ____

Home Phone:____ Work Phone:________________________________ Ext.________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:____Date:__________________

Printed name of patient or personal representative:_________________________________ Relationship to patient: ________________

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: ____

____

____

____

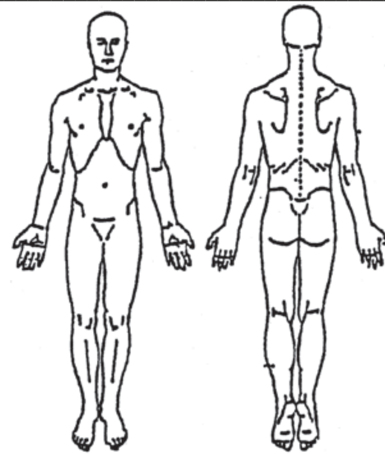
____

____

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 ____