

PATIENT REGISTRATION FORM (eCW)

(Please print)

PATIENT INFORMATION

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:


**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

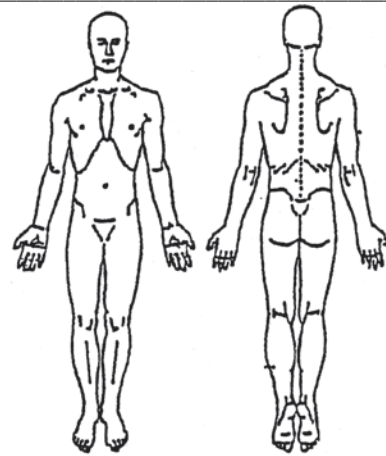
\_\_\_\_\_

\_\_\_\_\_

**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 \_\_\_\_\_