



PATIENT REGISTRATION AND HISTORY

Patient Name (please print): _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Sex: Male Female Age: _____ D.O.B. _____

Height: _____ Weight: _____

Single Married Widowed Divorced Separated

Occupation: _____ Employer: _____

Employer Address: _____ City, State, Zip: _____

Employer Phone: _____

Spouse Name: _____ D.O.B. _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

ASSIGNMENT AND RELEASE

I, the undersigned, verify that I (or my dependent) have Insurance coverage and assign directly to Atlas Physical Therapy, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Atlas Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____

Date: _____

(TURN OVER)

MEDICAL HISTORY

Please answer "Yes" or "No" to indicate if you *have* or *had* any of the following:

Infectious Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes/Low Blood Sugars	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Lesions (any open sores)	<input type="checkbox"/> yes <input type="checkbox"/> No

Please list all surgeries you have had: _____

Have you taken any special medical test (CAT scan, MRI, EKG, X-rays, etc.) _____

Have you had any orthopedic problems? _____

Family Physician: _____ Date of last visit _____

Orthopod: _____ Date of last visit _____

Podiatrist: _____ Date of last visit _____

Why were you referred to physical therapy? _____

Is this auto related? Yes No Work Related? Yes No

Other? _____

Medications:

Please list all medications, including over the counter medications that you are taking:

Allergies:

Please indicate if you are allergic to the following:

Adhesive Tape latex Other: _____

Who can we thank for referring you to us today? _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give permission to Atlas Physical Therapy, Inc. to administer and perform treatments and procedures as may be deemed necessary by my physician.

Patient Signature: _____

Date: _____