PTI
PHYSICAL THERAPY
INSTITUTE

PATIENT REGISTRATION
(Please print)

Today's Date: _____

Patient's Name: _____
Please list your name exactly how it reads on your insurance card

DOB: _____ SSN: _____

Email Address:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Contact Number: (_____) _____
Home Cell Work

Secondary Contact Number: (_____) _____
Home Cell Work

Emergency Contact: _____ (_____) _____
(Name) (Phone number)

Responsible Party (if patient is a minor): _____

Date of First Doctor Visit for this Injury: _____ Height:_____ Weight:_____

****Required** Physician Name: _____**

Attorney Name/Phone, if involved in case: _____

Is this injury due to a motor vehicle accident: ☐Y ☐N *If yes, what is the date of injury: _____

Have you had Surgery? ☐Y ☐N *If yes, Type & Date of Surgery:
_____

Previous Treatment for this injury including diagnostic testing (ex: MRI or Xray):_____

_____

Past Medical History relevant to this injury/episode:_____

_____

_____

List any other information that would assist us in your care: _____

_____

Are you aware of your diagnosis and prognosis as explained by your doctor? ☐Y ☐ N

What are your rehabilitation expectations/goals while in this program? _____

_____

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Patient Name: _____

Medical History Questionnaire

Please circle all that apply below:

Arthritis	**Seizures**	**Depression**
Osteoporosis	**Headaches**	**Prior Surgery**
Asthma	**Diabetes Type I or II**	**Prosthesis/Implants**
Angina	**Previous Accidents**	**Sleep Dysfunction**
High Blood Pressure	**Allergies**	**Cancer**
Stroke or TIA	**Incontinence**	**Heart Attack**
Pacemaker	**Anxiety or Panic Disorders**	**Other Disorders**
Congestive Heart Failure or Heart Disease	**Peripheral Vascular Disease (or Claudication)**	**Kidney, Bladder, Prostate or Urination Problems**
Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)	**Gastrointestinal Disease (Ulcer, hernia, reflux, bowel, liver, gall bladder)**	**Visual Impairment (such as cataracts, glaucoma, macular degeneration)**
Hearing Impairment (very hard of hearing, even with hearing aids)	**Hepatitis, Tuberculosis, or other blood-borne condition**	**Neurological Disease (such as Multiple Sclerosis or Parkinsons)**
Chronic Obstructive Pulmonary Disease (COPD)	**Acquired Respiratory Distress Syndrome (ARDS)**	**Emphysema**

Initial each statement and sign/date below:

_____I understand & agree that regardless of the insurance status, I am responsible for the balance on this account for any services rendered.

_____I give Physical Therapy Institute consent to provide medical care to properly diagnose and treat my physical condition. I understand it is my responsibility to notify Physical Therapy Institute of any insurance changes.

_____I have reviewed Physical Therapy Institute's Notice of Privacy Practices. A copy for my record is available upon request. A Patient Request to Access Protected Health Information (PHI) Form must be completed to obtain my medical or billing records. I agree that PTI can use my PHI in accordance with the Notice of Privacy Practices.

_____I agree to notify PTI within 24 hours of my inability to attend any scheduled appointments for any reason. If notice is not given, the patient will receive 1 warning, upon the second offense the patient will be charged 25$ to offset cost incurred by PTI's inability to offer this appointment time to another patient. After three no show appointments, or cancellations with less than 1 hours' notice, PTI holds the right to terminate the patient/provider relationship.

_____ _____

Patient/Guardian Signature **Date**