Montefiore

Patient Name: _____ MRN: _____

Patient D.O.B.: _____ Date: _____

PATIENT REGISTRATION FORM

Patient Name: _____ Preferred: _____

Address, City, State, Zip: _____

_____

DOB: _____

Email Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Appointment Reminder Method	
☐ Home Phone	☐ Cell Phone/Text
☐ Work Phone	☐ Email

Pronoun (optional): ☐ He ☐ She ☐ They ☐ Ze ☑ Ey

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☑ Married Partner's Name: _____

General Physician: _____ Referred By: _____

Have you had Physical Therapy treatment since January of this year? ☐ No ☐ Yes # of Visits: _____

Have you had Chiropractic treatment since January of this year? ☐ No ☐ Yes # of Visits: _____

Have you had Home Healthcare in the last 30 days? ☐ No ☐ Yes

If yes, Home Healthcare Provider: _____

Emergency Contact

Name: _____ Relationship: _____

Contact: _____

CONSENT TO TREAT / ASSIGNMENT OF BENEFITS

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Montefiore and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Montefiore. I authorize the filing of claims to my insurance plan and authorize Montefiore to release necessary health information related to these services to process the claims.

I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

_____ _____

Patient / Guardian Signature Date

_____

Print Name and Relationship to the Patient

Montefiore

Patient Name: _____ MRN: _____

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COMMERCIAL INSURANCE INFORMATION [if applicable]

Please Note: A copy of your insurance card(s) will be kept on file.
The patient is responsible to provide their most current insurance information.

Primary Insurance: _____ Secondary Insurance: _____

Group #: _____ Policy #: _____ Group #: _____ Policy #: _____

Subscriber Information: _____ Subscriber Information: _____

Name: _____ Name: _____

DOB: _____ DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION [if applicable]

What type of insurance do you plan to bill for these services? ☐ Auto Insurance ☐ Worker's Comp ☐ 3rd Party

In addition to providing the Case Information below – if billing your Auto Insurance, please also provide your Health Insurance carrier information and provide a copy of your insurance card

Insurance Carrier: _____ Group #: _____

Name of Insured: _____ Policy #: _____

Case Information – work related, MVA, personal injury; complete below information

☐ MVA ☐ 3rd Party ☐ WC Date of Accident: _____ State Accident Occurred: _____

Name of Employer / Insured: _____ Phone #: _____

Address: _____

Claim or Case #: _____ Name of Nurse Case Manager/ Adjustor: _____

Phone # for Nurse Case Manager / Adjustor: _____ Fax #: _____

Do you intend to file liability suit or is litigation pending? ☐ Yes ☐ No

If yes, please provide Attorney's Name: _____ Phone #: _____

PATIENT ELECT to SELF-PAY FOR SERVICES [if applicable]

If you do not want Montefiore to file claims to your personal health insurance, please read and sign below or please indicate if you do not have personal health insurance and sign below.

I acknowledge and understand and agree that:

- ✓ I am covered by the health insurance plan.
- ✓ The Health Plan under which I am covered includes benefits for some or all the services provided by Montefiore.
- ✓ Despite the above, I do not wish Montefiore to submit a claim to my Health Plan for services provided to me.
- ✓ Until such time as I may otherwise advise Montefiore in writing, I elect to pay for all services I receive at their self-pay rates.
- ✓ By election to self-pay for services, I understand that Montefiore will not be submitting claims to my Health Plan and that any payments I make to Montefiore will NOT be credited toward satisfying any deductibles, plan maximums, etc.
- ✓ I have read the Election to Self-Pay for Services and have had the opportunity to ask any questions I may have, and my questions have been answered to my satisfaction.

☐ I do not have health insurance coverage.

_____ _____

Patient / Guardian Signature Date

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PATIENT HEALTH QUESTIONNAIRE

Occupation: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Leisure Activities / Hobbies: _____

Are you? ☐ Right-handed ☐ Left-handed

Where do you live? ☐ Private Home ☐ Apartment / Rented Room ☐ Assisted Living / Group Home

☐ Hospice ☐ Other: _____

With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others

☐ Child ☐ Other: _____

Does your home have? ☐ Stairs, NO Railing ☐ Stairs, Railing

☐ Ramps ☐ Uneven Terrain

Please Explain: _____

How many times have you fallen in the past 12 months? _____ Did it result in an injury? ☐ Yes ☐ No

Do you have a fear of falling? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

General Health Status ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below.

_____

SURGERY / HOSPITALIZATION (including date and reason)

_____ _____

_____ _____

CURRENT MEDICATIONS (including prescription, over the counter, and herbal)

You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route	
			☐ Oral ☐ Patch ☐ Topical ☐ Other	
			☐ Oral ☐ Patch ☐ Topical ☐ Other	
			☐ Oral ☐ Patch ☐ Topical ☐ Other	
			☐ Oral ☐ Patch ☐ Topical ☐ Other	
			☐ Oral ☐ Patch ☐ Topical ☐ Other	

Provider (print name): _____ Date: _____

Signature / Credentials: _____ Time: _____ AM / PM

Montefiore

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CURRENT CONDITION

When did this problem(s) first begin / date of onset? _____

If chronic, when did you seek medical treatment? _____

Is your condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery: _____

Describe the problem(s). _____

Explain how the problem(s) occurred. _____

Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times: _____

Are your symptoms worse in: ☐ Morning ☐ Afternoon

☐ Evening ☐ Night ☐ Same All Day

How are you taking care of the problem(s) now? _____

What is your current pain level (0 – 10; 0 no pain) _____

My pain / problem is slowly getting: ☐ Worse ☐ Better ☐ Staying the Same

My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%)

☐ Occasionally (50%) ☐ Once in a While (25%)

Do you have any numbness, tingling or burning? ☐ Yes ☐ No

If yes, please check one: ☐ Constantly ☐ Intermittently

What functions could you perform before, that you are now unable to do?

_____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.

_____

Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.

_____

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

If yes, please tell us what it is: _____

What are you goals for therapy? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING

Nausea or Vomiting	☐ Yes	☐ No	Chest Pains (Angina)	☐ Yes	☐ No
Productive/Chronic Cough	☐ Yes	☐ No	Pain Wakes Me at Night	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No	Recent Fever, Chills, Sweats	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Difficulty Sleeping	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Visual Problems	☐ Yes	☐ No	Heart Palpitations	☐ Yes	☐ No
Hearing Loss/Ringing in Ears	☐ Yes	☐ No	Loss of Appetite	☐ Yes	☐ No
Difficulty Walking	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Unusual Weakness	☐ Yes	☐ No	Fatigue or Myalgia	☐ Yes	☐ No
Joint Pain or Swelling	☐ Yes	☐ No	Unexplained Weight Changes	☐ Yes	☐ No

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HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

Allergies	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Hepatitis, If Yes, Type:	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No	Kidney Disease/Problems	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Spinal Cord Stimulator	☐ Yes	☐ No
Bowel or Bladder Disorder	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Cancer, If yes, Site:	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cardiac Conditions	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	Peripheral Vascular Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Auto Immune Disease	☐ Yes	☐ No	Fractures	☐ Yes	☐ No
If yes, Type: _____					

SOCIAL HISTORY / WELLNESS

Do you drink alcoholic beverages?	☐ Yes	☐ No	Do you use tobacco?	☐ Yes	☐ No

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

☐ At least 3 times per week ☐ 1-2 times per week ☐ seldom or never

FINANCIAL POLICY

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Financial Responsibility: ☐ Self ☐ Parent / Legal Guardian Name and DOB _____

Address and Phone Number, if Different from Above: _____

2nd Contact Info and Phone: _____ Relation: _____

_____ _____

Patient / Guardian Signature Date

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

_____ _____

Patient / Guardian Signature Date

Provider (print name): _____ Date: _____

Signature / Credentials: _____ Time: _____ AM / PM