BENTZ PHYSICAL THERAPY REGISTRATION FORM

Name _____ Home/Cell Phone _____

Address _____ City, State, Zip _____

Email address _____ Date of Birth ___/___/____ Last 4 of SS# _____

Single Married Student (P/T or F/T) Occupation _____ Employer _____

*If patient is under 18 years of age, Name / Ph. # of Responsible Party _____

Emergency Contact Name _____ Phone _____ Relationship _____

PAYMENT INFORMATION: (NOT APPLICABLE FOR WORKER'S COMP OR SELF-PAY PATIENTS)

Insurance Company _____ ID# _____ Group# _____

Insurance Policy Holder _____ Relationship _____ Date of Birth ___/___/___

Address _____ Phone _____

Secondary Insurance Company _____ ID# _____ Group # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please initial.)

_____I authorize Bentz Physical Therapy to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize payment of medical benefits to Bentz Physical Therapy. I understand that I am financially responsible for all copayments, deductibles, co-insurance, and services NOT COVERED under my benefits plan. I have received and understand the credit and collection policy of this company and agree to abide by the policy stated therein.

MY CONDITION INFORMATION:

☐Auto/Personal Injury: Date of Injury ___/___/___

☐ Surgery: Date ___/___/___ Type? _____

☐Work Related: Date of Injury ___/___/___ Adjustor Name _____ Claim #_____

☐No Injury, I just have pain or difficulty. Adjustor Phone # _____

REFERRAL INFORMATION: (How did you hear about us? Please give details.)

☐Physician: Referring _____ Primary Care _____ ☐Insurance/Directory

☐Friend/Family_____ ☐Internet Search_____ ☐Social Media_____ ☐Other _____

PATIENT POLICY AND H.I.P.A.A. CONSENT (A copy can be provided upon request.)

_____ (Initial) I acknowledge that I have been provided an opportunity to review the Patient Policy/H.I.P.A.A. consents.

I designate the following individual to have access to information about me that is created by or on behalf of Bentz Physical Therapy.

Authorized Individual Name _____ Relationship_____

COMMUNICATION CONSENT (Please initial.)

I consent to receiving communication from Bentz Physical Therapy to the phone number or email address that I have provided. I understand that this may include; health notifications, appointment information, announcements and billing.

_____ Phone _____ Voicemail _____ Text Messaging _____ Email

I have read and completed this information sheet and certify this information is true and correct to the best of my knowledge.

Signature _____ Date _____

BENTZ PHYSICAL THERAPY- Confidential Health History

Name:_____ Date:_____ Age:_____ Height:_____ Weight:_____

Is anyone currently coming to your home to give you health care? ☐Yes ☐No

Please describe the problems/symptoms you are currently experiencing:_____

_____

_____

How/When did you symptoms begin?_____

_____

Overall are your symptoms?: ☐ Getting Better ☐ Staying the same ☐ Getting Worse

What makes your symptoms WORSE?_____

BETTER?_____

How often do you experience your symptoms? ☐Constant ☐Frequent ☐ Occasional ☐ Intermittent ☐Other_____

What tests, treatments or procedures have you had for these symptoms or condition?_____

_____

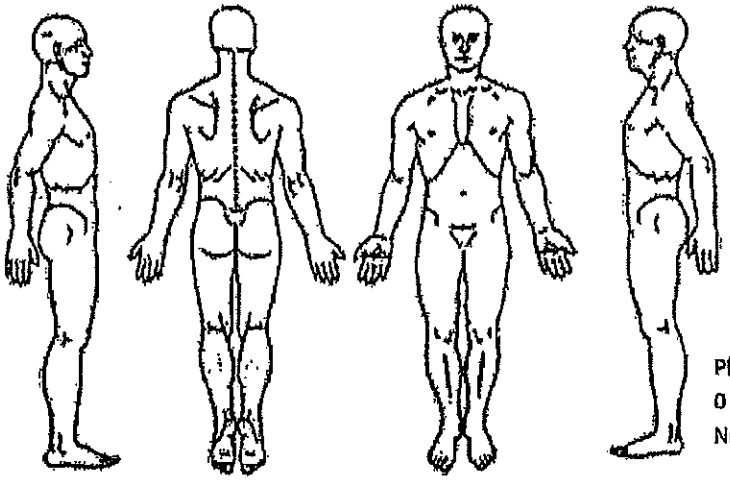
Do you have a follow up appointment with the doctor that referred you for physical therapy? ☐No ☐Yes, Date:_____

Have you ever had physical/occupational therapy prior to this occasion? ☐Yes ☐No

Please rank the following in regard to your health care needs 1-4: (1=most important, 4=least important)

___Experience ___Outcomes ___Price ___Convenience

Using the diagram below, mark all area(s) where you are experiencing symptoms (Use the symbols to describe symptoms)



Aching *****

Numbness ====

Pins and Needles ooooo

Burning XXXX

Stabbing /////

Please Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

Medical History (Check all conditions you HAVE or HAD in the past)

☐Anemia	☐Cancer	☐HIV positive	☐Psychiatric care
☐Arthritis	☐Diabetes	☐Neurological disorders	☐Smoker
☐Asthma	☐Dizziness	☐Night sweats	☐Stroke
☐Allergies	☐Fractures dislocations	☐Pacemaker	☐High blood pressure
☐Bleeding disorders	☐Fibromyalgia	☐Persistent night pain	☐Chest pain
☐Bowel or Bladder difficulty	☐Hernia	☐Pregnant NOW/RECENT	☐Other_____

Surgeries (List ALL previous procedures Ex. Heart, abdominal, bone, ligament, other)_____

_____

Allergies (Substances/Medications)_____

_____

Thank you for taking time to complete this evaluation. Our staff hopes to provide you with excellent care to reduce symptoms and restore you to normal function.

Name:_____ Date:_____

Medications, Over-the Counters, Herbals, and Supplements

(List all medicines you are currently taking, as well as dosage, frequency, and route of administration)

Name	Dosage	Frequency	Route	Purpose of taking