

# patient Registration

Date last seen by referring MD: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of next MD visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Responsible Party (if not patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referring Physician \_\_\_\_\_

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

Cell Phone(\_\_\_\_\_) \_\_\_\_\_ Email address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: [ ]Male [ ]Female Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed

Patient Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Pt. Employer Phone #: \_\_\_\_\_ Work Status: { }Full time { }Part time { } N/A

## Insurance Information

*Primary* Insurance Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Insurance Phone Number(\_\_\_\_\_) \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policyholder Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policyholder Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policyholder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Policyholder Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer Phone Number(\_\_\_\_\_) \_\_\_\_\_ Policyholder Relationship to Patient \_\_\_\_\_

*Secondary* Insurance Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Insurance Phone Number(\_\_\_\_\_) \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policyholder Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policyholder Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policyholder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Policyholder Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer Phone Number(\_\_\_\_\_) \_\_\_\_\_ PH Relationship to Patient \_\_\_\_\_

## Medicare Secondary Payer (MSP) Information (Medicare Patients Only)

Please answer questions 1 through 6 if you receive Medicare benefits (Part A, Part B or Disability).

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, Moreau Physical Therapy is required to gather the following information to determine if Medicare is your primary insurance:

1. Is illness/injury due to an automobile, liability, or workers' compensation accident? [ ]Yes [ ]No
2. Is illness covered by the Black Lung Program or Veterans Affairs Program? [ ]Yes [ ]No
3. If under age 65, are you a renal dialysis patient in your first 12 months of Medicare entitlement? [ ]Yes [ ]No
4. If under age 65, is your Medicare coverage due to disability? [ ]Yes [ ]No If yes, date began:\_\_\_\_/\_\_\_\_/\_\_\_\_
5. Is patient covered by an Employer Group Health Plan through patient's employer or spouse's or family member's current employer (i.e., Employer Group Health Plan is not the same as Supplemental Coverage)? [ ]Yes [ ]No
6. Date of retirement: Patient\_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse\_\_\_\_/\_\_\_\_/\_\_\_\_

If patient responds "Yes" to any questions above, please complete information below:

Name of Insurance Company\_\_\_\_\_

Address\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_

Insurance Company Telephone Number/Contact(\_\_\_\_\_)\_\_\_\_\_

Name of Policyholder\_\_\_\_\_

Relationship to Policyholder\_\_\_\_\_ Policy Number\_\_\_\_\_

Policyholder's Employer\_\_\_\_\_

Address\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_

### Patient History/Condition/Injury (All Patients)

Gender: Male Female Smoker: Yes No Pregnant: Yes No

1) Main reason/goal for attending therapy: \_\_\_\_\_

2) Are you currently working? Y N

3) Are you allergic to latex? Y N Do you take blood thinners? Y N

4) Have you ever had an adverse reaction to heat/cold packs or prolonged exercise? Y N

5) Past Medical History: (circle all you have or have had in the past)

Cancer

High Blood Pressure

Osteoporosis

Allergies/ Asthma

Liver Disease

Sexually Transmitted Disease

Diabetes

Heart Disease

Osteoarthritis

Ulcers

Stroke

Kidney Disease

Angina/ Chest Pain

Rheumatoid Arthritis

Fibromyalgia

Lung Disease

6) Currently I am experiencing: (circle all that apply)

Unexpected Weight Loss	Numbness/Tingling	Fever/Chills/Sweats
Poor Balance	Changes in Appetite	Difficulty swallowing
Depression	Shortness of Breath	Dizziness
Headaches	Changes in bowel or bladder functions	
Nausea/ Vomiting	Increased pain at night	

7) Do you have..... Pacemaker: Y N Metal Implants: Y N Allergies: Y N

8) Have you ever had a fracture? Y N If so, where? \_\_\_\_\_

9) List any previous surgeries: \_\_\_\_\_  
\_\_\_\_\_

10) Are you on medication? Y N If so, please list them : \_\_\_\_\_  
\_\_\_\_\_

11) Mark an "X" on the line below that best describes your level of pain at this moment.

No Pain \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ Worst possible

12) Your pain is (circle one): constant periodic occasional

13) Where are you currently having symptoms? \_\_\_\_\_

14) Have you received any treatment for this problem? Y N If yes, what type of treatment did you  
Have, and did it help you? \_\_\_\_\_

15) How are you able to sleep at night? Fine Moderate Only with Medication

16) Does anything make your symptoms better? \_\_\_\_\_

17) Have you had an X-ray, MRI, or other imaging study? Y N If yes, where and when:  
\_\_\_\_\_

18) What are three activities that you are unable to do or are having difficulty with as a result of your problem:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

19) On the diagram below, please shade the area of your body where your pain is present:



