Hastings Physical Therapy
Spine, Sport & Extremity Center

2307 Osborne Drive West
Hastings, NE 68901
Phone: 402.462.2665
Fax: 402.462.2668

Patient Registration Form

Patient Information:

Legal Name: _____ Nickname: _____
(first) (M.I.) (last)

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Gender: ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ lbs. E-mail: _____

Home #: (_____)_____ Okay to call? ☐ Yes ☐ No

Work #: (_____)_____ Okay to call? ☐ Yes ☐ No

Cell #: (_____)_____ Okay to call? ☐ Yes ☐ No

Employer: _____ Address: _____ Phone #: (_____)_____

Referring Doctor: _____ Primary Doctor: _____

Marital Status: ☐ Married ☐ Single ☐ Other Student: ☐ Full-time ☐ Part-time

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Responsible Party: ☐ Self ☐ Spouse ☐ Other_____
☐ Parent ☐ Legal Guardian

Legal Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Emergency Contact:

Full Name: _____ Relationship to patient: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Primary Insurance Holder's Information: ☐ **Check if same as patient**

Co. Name: _____ Insured Name: _____ Relationship: _____

Primary Phone: (_____)_____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Employer Name: _____ Employer Phone #: (_____)_____

Secondary Insurance Holder's Information: ☐ **Check if same as patient**

Co. Name: _____ Insured Name: _____ Relationship: _____

Primary Phone: (_____)_____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Employer Name: _____ Employer Phone #: (_____)_____

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Workers' Compensation:

First report of injury been filed: Yes / No
Employer (at time of injury): _____ Date of injury: _____/_____/_____
Supervisor's Name: _____Phone: (_____)_____
Worker's Comp. Ins. Co.: _____ Phone: (_____)_____
Claim #: _____ Case Manager: _____
Address: _____ City: _____ State: _____ Zip: _____

Automobile Accident/Liability Claims:

Is the auto related? Yes / No
Is this a liability claim? Yes / No
What is the date of the motor vehicle accident or the liability injury? _____/_____/_____
What is your Auto Accident or Liability Claim # ? _____
Ins. Co. Responsible for Payment: _____ Ins. Contact Person: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____)_____ Name of Insured: _____

Attorney Information:

Do you have an attorney representing you for the claim(s) listed above? Yes / No
Attorney's Name: _____ Attorney's Phone: (_____)_____
Address: _____ City: _____ State: _____ Zip: _____

PATIENT AGREEMENT FORM - Patients Please Read All Three Parts and Sign

CONSENT FOR TREATMENT
I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such procedures, physical examination and such clinical treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as the results of treatment of examination provided by Hastings Physical Therapy Spine, Sport & Extremity Center.

AUTHORIZATION FOR RELEASE OF INFORMATION
The undersigned authorized Hastings Physical Therapy Spine, Sport & Extremity Center to release the patient's medical information to the referring physician, to the patient's health or insurance plan to _____ (person/attorney/facility) for the purposes of processing claims, obtaining payment for services or for personal reasons.

FINANCIAL AGREEMENT
The undersigned agree, in consideration of the services to be rendered to the patient, to pay Hastings Physical Therapy Spine, Sport & Extremity Center. I understand that third party payment is accepted as a courtesy and accept personal responsibility for payment of any and all charges within 30 days of the date of service.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND RECEIVED PRIVACY & FINANCIAL POLICIES, AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____	_____	_____
Patient's Printed Name	Signature of Patient or Legal Guardian	Date

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For Therapist Use Only
Diagnosis: _____ ICD-9 _____

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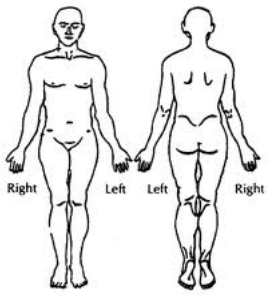
Patient Health Profile

Patient's Name: _____ **Date:** _____

Please circle, on the drawing(s) below, the area(s) where you feel pain.



HEALTH HISTORY:

What will we be treating you for? _____

How did the injury occur? _____

Date of injury: _____/_____/_____ **OR** Approximately when did you first notice symptoms? _____/_____ /_____

Please rate your pain on a scale of 0 (no pain) to 10 (worst pain imaginable:

	0	1	2	3	4	5	6	7	8	9	10
Current level of pain	○	○	○	○	○	○	○	○	○	○	○
Least pain (with the injury)	○	○	○	○	○	○	○	○	○	○	○
Most pain (with the injury)	○	○	○	○	○	○	○	○	○	○	○

Medical/Surgical History:

1. Have you had any x-rays, sonograms, CT scans, MRI, or other imaging done recently? Yes / No
   If yes, what? _____ When? _____/_____/_____ Results: _____

2. Any other clinical test? Yes / No
   If yes, please describe: _____

3. Please list any operations that you have ever had and the date(s):
   Operation: _____ Date: _____/_____/_____
   _____ Date: _____/_____/_____
   _____ Date: _____/_____/_____

4. Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or other implants? Yes / No
   If yes, please describe: _____

5. Within the current year, have you received any treatment at another facility including physical therapy, occupational therapy, speech therapy, or chiropractic service? Yes / No
   If yes, please describe: _____

Medicare Patients Only:

Have you received treatment from a skilled nurse or home health care in the last 30 days? ☐ Yes ☐ No

Is the patient covered by a health insurance plan through their own current employer or that of a family member? ☐ Yes ☐ No

Is the patient a veteran? If yes, answer the following questions below: ☐ Yes ☐ No

a. Did the VA refer the patient for treatment? ☐ Yes ☐ No

b. Does the patient have a VA "Free Basis Id card"? ☐ Yes ☐ No

How did you hear about HPT or whom may we thank for recommending our clinic?

☐ Doctor: _____ ☐ Drove by ☐ Sign
☐ Friend: _____ ☐ Church ☐ Radio
☐ Coach: _____ ☐ Internet ☐ Other

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Patient Health Profile

HEALTH HISTORY:

Do you currently use tobacco? (smoking or chewing)	☐ Yes	☐ No	Have you smoked in the past?	☐ Yes	☐ No

Have you ever been told that you have any of the following:

Cancer:	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Autoimmune Deficiency	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Blood born diseases (HIV, HEPC, etc.)	☐ Yes	☐ No			

Do you have a history of any of the following:

Allergies/Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Adhesives/Latex Allergy	☐ Yes	☐ No

In the past 3 months have you had or experience:

Numbness or Tingling	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Leg/Ankle Swelling	☐ Yes	☐ No	Changes in Bowel Function	☐ Yes	☐ No
Weakness or Fatigue	☐ Yes	☐ No	Changes in Bladder Function	☐ Yes	☐ No
Unexplained Weight Loss	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No

Fall History:

- ☐ In the past year, I have no falls
- ☐ I have just started to lose my balance/fall
- ☐ I fall occasionally
- ☐ I fall frequently (more than 2 times during the past 6 months)
- ☐ Certain factors make me cautious, such as: _____

Please provide a list or copy of all your current medications and supplements below:

Name of Medication/Strength (ie: Aspirin/50mg)	Dosage (ie: 2 pills)	Frequency ie: 2x a day)