QUINNIPIAC PHYSICAL THERAPY
& SPORTS MEDICINE, P.C.

Today's Date	**REGISTRATION FORM**

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Sex ☐Male☐ Female	Birthdate

Marital Status ☐Single ☐Mar☐ Div ☐Sep ☐Wid	Soc. Sec. #	Home Phone #	Cell Phone #

Street address	City	State	Zip Code

Email address:	Appointment Reminder ☐Text ☐ Voice

Occupation	Employer (with address)	Employer Phone #

Primary Care Physician	Address	MD Phone #

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone #	Cell phone #

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Primary Insurance	Policy #

Subscriber's Name	Subscriber's Social Security #	Birthdate:

Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Secondary insurance	Policy #

Subscriber's Name	Subscriber's Social Security #	Birthdate:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Quinnipiac Physical Therapy & Sports Medicine, P.C. I understand that I am financially responsible for any balance. I also authorize Quinnipiac Physical Therapy & Sports Medicine, P.C. to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

Above information reviewed with no changes:

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

QUINNIPIAC PHYSICAL THERAPY & SPORTS MEDICINE, P.C.
MEDICAL HISTORY

Name:_____ Date:_____

Name of Referring Physician: _____

Patient's Occupation: _____

Condition Related to: ☐ Illness ☐ Employment ☐ Auto ☐ Other Date of Injury/Accident:_____

What are your present symptoms and when did they start? _____

_____

On a scale of 1 to 10 how would you rate your symptoms?
☐1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐6 ☐ 7 ☐ 8 ☐9 ☐ 10

Do you have:
PAIN ☐ TINGLING ☐ NUMBNESS ☐ DIZZINESS ☐

How would you describe it:
☐SHARP ☐DULL ☐THROBBING ☐BURNING ☐ACHING ☐CONSTANT ☐INTERMITTENT ☐OTHER

Please check if any of these are applicable to you:

☐Arthritis	☐Headaches	☐Peripheral neuropathy
☐Asthma	☐Heart Disease	☐Repeated infections
☐Blood disorders	☐Hypertension	☐Skin diseases
☐Broken bones/fractures	☐Infectious disease (e.g. TB, hepatitis)	☐Stomach problems/ulcers
☐Cancer	☐Kidney problems	☐Stroke
☐Depression	☐Low Back Pain	☐Thyroid problems
☐Developmental/growth problem	☐Multiple Sclerosis	☐HIV/AIDS
☐Diabetes	☐Muscular dystrophy	☐Are pregnant?
☐Emphysema	☐Osteoporosis	☐Use tobacco?
☐Head injury	☐Parkinson's Disease	☐Have a pacemaker/defibrillator?

What makes your symptoms better? _____ worse?_____

Are you allergic to latex or adhesives? ☐Yes ☐ No Other, please list_____

Have you recently had an x-ray or other diagnostic test? ☐Yes ☐ No

If yes, please list tests and where they were done?_____

_____

What kind of surgeries have you had? _____

Date of Surgery? _____

Have you received physical therapy before? ☐Yes ☐No If yes, when?_____

Where?_____

Any other comments, problems?_____

*******IF YOU TAKE ANY MEDICATIONS, PLEASE FILL OUT THE MEDICATION LIST*******

QUINNIPIAC PHYSICAL THERAPY & SPORTS MEDICINE
MEDICATION LIST

Prescription Medications

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, intramuscular)

Over-the Counter Medications

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, intramuscular)

Herbal/Vitamin/Mineral/Dietary Supplements

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, intramuscular)

QUINNIPIAC PHYSICAL THERAPY AND SPORTS MEDICINE, P.C.

Consent for Use or Disclosure of Health Information

The effective date of this privacy notice is April 14, 2003

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date