OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC.
PATIENT REGISTRATION FORM

DATE____________________ THERAPIST_________________

PATIENT NAME (FIRST)_______________________ (MI)______ (LAST)_______________________________

ADDRESS____________________________________CITY_______________________ZIP_______________

PHONE: (CELL)_____________________(WORK)_____________________(HOME)______________________

EMAIL:__________________________________

CONTACT BY EMAIL? YES NO PERMISSION TO TEXT? ? YES NO

DATE OF BIRTH _____/_____/_____ AGE:______

SEX: Male____ Female____ MARITAL STATUS: Single:____Married_____Divorced_____Widowed_____

CURRENT EMPLOYER____

BUSINESS ADDRESS___________________________________CITY ___________________ ZIP____________

OCCUPATION___________________________ IF RETIRED, DATE OF RETIREMENT_____/_____/_____

SPOUSE'S NAME___________________________________ CELL PHONE __________________________

EMERGENCY CONTACT_____________________________ CELL PHONE__________________________

IF PATIENT IS 18 YEARS OF AGE OR UNDER OR IS A FULL-TIME STUDENT, PLEASE COMPLETE:

FATHER'S NAME:___________________________________ CELL PHONE___________________________

EMPLOYER_______________________________________ WORK PHONE____________________________

IF ADDRESS IS SAME AS ABOVE PLEASE CHECK _____ IF DIFFERENT PLEASE FILL OUT.

ADDRESS____________________________ CITY_________________ZIP________ PHONE _______________

MOTHER'S NAME:__________________________________ CELL PHONE___________________________

EMPLOYER_______________________________________ WORK PHONE____________________________

IF ADDRESS IS SAME AS ABOVE PLEASE CHECK _____ IF DIFFERENT PLEASE FILL OUT.

ADDRESS____________________________ CITY_________________ZIP________ PHONE _______________

PHYSICIAN WHO SENT YOU____

PRESENT COMPLAINT____

DATE OF INJURY_____/_____/_____ AND/OR DATE OF SURGERY_____/_____/_____

WAS THIS RELATED TO: AUTO ACCIDENT_____ SPORTS______OTHER______

IF SPORTS RELATED, NAME OF SPORT________________NAME OF SCHOOL_________________________

HAVE YOU HAD:

MRI? NO YES IF YES, WHERE?___________________________________

XRAYS? NO YES IF YES, WHERE?___________________________________

OTHER APPLICABLE TESTS? NO YES IF YES, WHERE?___________________________________

PHYSICAL THERAPY THIS YEAR? NO YES IF YES, WHERE?___________________________________

PRIMARY INSURANCE____
POLICY HOLDERS NAME________________________________ DATE OF BIRTH_____/_____/_____
SSN___________________POLICY/ID #__________________________ GROUP #______________
SECONDARY INSURANCE____
POLICY HOLDERS NAME________________________________ DATE OF BIRTH_____/_____/_____
SSN___________________POLICY/ID #__________________________ GROUP #______________

PLEASE SELECT ONE OF THE FOLLOWING PAYMENT OPTIONS:

_____SELF-PAY – PAYMENT IN FULL AT EACH VISIT
_____HEALTH INSURANCE – PAYMENT OF UNMET DEDUCTIBLE AND PATIENT CO-PAY OR % EACH VISIT
_____* AUTO

_____* WORKERS COMPENSATION: CLAIMS FILED WITH (EMPLOYER NAME)_____________________

*FOR WORKERS COMPENSATION OR AUTO LIABILITY CASES, WE ALSO NEED YOUR HEALTH INSURANCE

***IF YOU INDICATED AN AUTO ACCIDENT, PLEASE COMPLETE THE FOLLOWING:**

NAME OF PARTY AT FAULT:____

HAVE YOU RETAINED AN ATTORNEY? YES_____ NO_____ IF YES, NAME________________________

ADDRESS_______________________CITY_______________ ZIP_________ PHONE______________

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS, AND RESPONSIBILITY

I authorize the medical treatment, which has been or will be provided to me or my dependent, as named above, by OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., and that I am the responsible party for any such charges incurred. Should I elect to have OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., file my insurance as a courtesy. I represent that I presently maintain medical insurance coverage, which will reimburse the charges for the care provided. If my medical insurance coverage is not sufficient to satisfy these charges in full, I acknowledge that the resulting balance is not covered by this assignment and I will be fully responsible for payment of this balance at the established rates of OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC.. I authorize the creditor to make a credit investigation, including employment verification, should this be necessary. I agree to be responsible for any reasonable collection costs and/or attorney's fees incurred in the collection of this account should it become delinquent. In consideration of medical services rendered by OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., I hereby assign, transfer, and set over to OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., all of my rights, title, and interest to medical reimbursement. I also authorize the release of any medical and/or billing information necessary to process claims.

____ ______________________________

(Signature of Responsible Party – Must be 18 or older) (Date)

____ ______________________________

(Signature of Policy Holder) (Signature of Witness)

Oconee Physical Therapy and Sports Rehabilitation
Past Medical History Form

Patient Name:_________________________ Date Completed:__________ Age: ___________

MEDICAL HISTORY:

Right / Left Handed   Male / Female
Height: __________ Weight:___________
Next Doctor Visit:___________________________

- What is the problem you are here for?
  ____
- Date of injury or when pain started:
  ____
- Date of Surgery (if applicable):_____________
- Check which apply to your injury:
  - ☐ Work-related
  - ☐ Motor vehicle accident
  - ☐ Athletic / recreational injury
  - ☐ Injury related to lifting or falling
  - ☐ Recurrence of previous injury
  - ☐ Cause unknown
  - ☐ Other:_____________________________
- Is this the first time you have had this pain?
  YES   NO   If NO, then when:_____________
  ____
- What treatments have you tried?
  Medications, Physical Therapy, Massage, Chiropractic, Surgery
- What medications are you taking?_________
  ____
  ____
  ____

SOCIAL HISTORY:

Do you Smoke? YES   NO   Drink Alcohol? YES   NO
Married? YES   NO   Children? YES   NO   #____
Do you regularly exercise? YES   NO

WORK HISTORY:

- Are you employed? YES   NO
- Are you presently working? YES   NO
  IF NO, then date of last work day:___________
- Current Occupation:______________________
- Where are you employed:_________________

PAST MEDICAL HISTORY:

•Check which apply:

- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Seizure Disorder
- ☐ Heart Disease
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Asthma
- ☐ None of the above

Other: ___________________________________

- Female: Are you Pregnant? YES   NO
- Indicate Surgeries and date or year:__________
  ____
  ____

•Check which apply:

- ☐ Chest Pain
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Balance Problems
- ☐ Change in bathroom habits
- ☐ Signficant weight loss
- ☐ Swelling
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Sleep problems

Other:______________________________________

PAIN AND SYMPTOMS: Circle the answer:

- Is your pain? Occasional   Continuous
- When is your pain the worst?
  Morning, Afternoon, Evening, Nighttime
- When is your pain the best?
  Morning, Afternoon, Evening, Nighttime
- Can you sleep? YES   NO
- What is your best sleeping position?
  Side, Back, Stomach, Other,__________
- Circle the number that rates your pain *right now*:
  None 1 2 3 4 5 6 7 8 9 10 Go to the hospital
- Circle the number that rates you pain *at worst:*
  None 1 2 3 4 5 6 7 8 9 10 Go to the hospital
- Circle the number that rates you pain *at best:*
  None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

Please check the answers that apply to you.

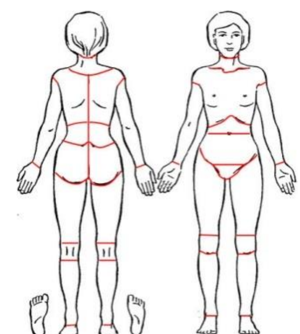
What makes your pain better?

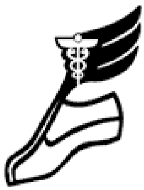
- ☐ Sitting
- ☐ Standing in one place
- ☐ Sleeping
- ☐ Walking
- ☐ Bending backward
- ☐ Lying flat
- ☐ Bending forward
- ☐ Other:___________________

What makes pain worse?

- ☐ Sitting/driving
- ☐ Standing in one place
- ☐ Walking
- ☐ Lifting/carrying
- ☐ Bending forwards
- ☐ Bending backwards
- ☐ Sleeping/lying flat
- ☐ Reaching above your head
- ☐ Walking up/down stairs

Mark where your symptoms are.





Physical Therapy & Sports Rehabilitation, Inc.

8081 Macon Highway Athens, Georgia 30606
phone: 706-769-6261 fax: 706-769-6316

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:____Date of Birth:_________________________

I have received a copy of the Notice of Privacy Practices for the above named practice. I understand that at any time I can review the HIPAA manual of Oconee Physical Therapy and Sports Rehabilitation upon request at any time.

____ __________________________________
Signature of Patient Date

For Office Use: We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:
_______An Emergency existed and a signature was not possible at the time.
_______The individual refused to sign.
_______Other: ____
Documented by:_______________________Date:_______________________________

Authorization for Release of Information

Oconee Physical Therapy and Sports Rehabilitation, Inc. is authorized to disclose protected health information to the entities named below:
______Leave information on voicemail or answering machine.
______Discuss information with the following named person(s):
______Spouse:____
______Child or Children:____
______Parent:____
______Other:____

All of my protected health information, financial information and appointment information generated at Oconee Physical Therapy and Sports Rehabilitation, Inc. and on file in my chart can be released to the above noted individual(s).

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization. I understand that I have the right to revoke this authorization at any time by sending a written notification to the attention of Megan Lewis at the above address. I understand that a revocation is not effective in cases where the information has already been disclosed. I understand that I have a right to inspect my protected health information within 48 hours by contacting the compliance officer, Megan Lewis, at the above address. I understand that my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

Print Name of Patient or Personal Representative:______________________________________

Signature:____ Date:__________________________