

Mady and Mules Physical Therapy & Sports Rehabilitation

PATIENT REGISTRATION

TODAY'S DATE: _____

PATIENT'S NAME: _____ SEX: FEMALE / MALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ E-MAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ SOC.SEC.#: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

OCCUPATION: _____ EMPLOYER: _____

WHO REFERRED YOU TO THIS FACILITY? (CIRCLE ONE): SELF PHYSICIAN FRIEND OTHER: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

PROBLEM THAT BRINGS YOU HERE: _____

DATE OF ONSET/SYMPTOMS/SURGERY: _____

TESTS OR PROCEDURES PERFORMED (X-RAYS, EMG, CT SCAN, ETC.): _____

SPOUSE'S NAME (OR PARENT'S NAME IF MINOR): _____

SPOUSE/PARENT EMPLOYED BY: _____ WORK PHONE #: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____ PHONE #: _____ RELATIONSHIP: _____

PATIENT'S AUTHORIZATION

I give my consent to allow Mady and Mules Physical Therapy & Sports Rehabilitation (MMPT) to evaluate and, if necessary, to treat me. _____ (initial)

I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to MMPT. I hereby authorize photocopies of this form to be as valid as the original. I authorize the electronic submission of my claims and the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to party who accepts assignment. I authorize payment of medical benefits to MMPT for services provided. _____ (initial)

I hereby acknowledge receipt of the MMPT Notice of Privacy Practices as they relate to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). _____ (initial)

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