Portera Rehabilitation

REGISTRATION

1. ABOUT YOU

Last Name | First Name | Middle Name or Initial | You prefer to be called:

Gender (at Birth)

○ Male ○ Female ○ Prefer not to answer

Birthdate: mm/dd/yyyy | Age | Social Security Number:

Your height | Your weight | How were you referred to our office?

Mailing/Street Address | City | State | ZipCode

Home Phone Number: | Work Phone Number: | Cell Phone | E-mail Address

How would you like to receive your appointment reminders?

○ Cell Phone ○ Email ○ Voice call

Who is you cell phone service provider?

Employer's Name/Company | Employer's Address, City, State, Zip | What is your Occupation?

Status:

○ Widowed ○ Separated ○ Divorced ○ Married ○ Single ○ Minor

Spouse's Name | Do you have children? ○ No ○ Yes | How many Children?

2. INSURANCE INFORMATION

Primary Health Insurance Co. Name | Insurance Co. Address, City, State, Zip | Insurance Co. Phone #

Insured's ID# | Group #: (Plan, Local, or Policy #) | Insured's Name

Relation to Patient | Insured's Date of Birth mm/dd/yyyy | Insured's Employer

Secondary Insurance | Insurance Co. Address, City, State, Zip | Insurance Co. Phone #

Insured's ID# | Group #(Plan, Local, or Policy #) | Insured's Name

Insured's Relation to Patient | Insured's Date of Birth mm/dd/yyyy | Insured's Employer

3. ACCOUNT INFORMATION

Person responsible for account | What is your relation to patient | Billing Address, City, State, Zip

Social Security # 222-33-4444 | Driver's License # | Work Phone #

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Please click to acknowledge you agree with the above statement.

○ I do not Agree ○ I Agree

What is your preferred payment method?

☐ Credit Card ☐ Check ☐ Cash

4. IN EVENT OF AN EMERGENCY

Whom should we contact?

Relation to Patient

Home Phone #

Work Phone #

Cell Phone #

Who is your Medical Doctor?

MD's Phone #

Notice Of Patient Responsibility

Please verify that you understand your financial responsibility by selecting "I agree." Let us know if we can assist you in any other way.

Financial Policy Agreement

We require a 24-hour notice for all cancellations. If the event of an emergency occurs after hours, please leave a message on the answering machine.

Your insurance policy requires the payment of co-payments and deductible amounts form you at the time of service. Your insurance company requires Portera Rehabilitation to collect you your co-payment or unmet deductible amount. Not adhering to these terms could be a violation of our contract with your insurance company and risk not being reimbursed for your treatment process. Portera Rehabilitation verifies benefits as a courtesy to you. However, Portera Rehabilitation does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans. If co-insurance responsibility has been established, we may ask that you make small payments towards the ending balance.

This is NOT intended to release/relieve or negate you from the responsibility of the final balance due. We reiterate again, Portera Rehabilitation verifies benefits as courtesy to you. Portera does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

Our Front Offices staff can accept payment form you in the form of credit card, check or cash. As a courtesy, we will bill your insurance company for their portion of the bill.

There will be a $50.00 cancellation/no show fee for all appointments that re not rescheduled or cancelled within 24 hours. Fees are due at your next scheduled appointment. Your insurance company does not cover these fees.

• Home Care Patients ONLY- There will be a $35.00 fee for verified appointments that are not honored (knock to unanswered door). This fee is not covered by your company and will be due at your next visit.

By Signing below you aknowledge this information and agree to our financial policy.

Print your full name and sign:

X _____ Ip Address

Medical History

5. REASON FOR VISIT

Reason for today's visit:

○ Wellness ○ Chronic pain ○ Old injury ○ New injury ○ Emergency

Are you in pain?

○ Yes ○ No

Using a scale from 0 to 10, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey:

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

The best your pain has been during the past 24 hours:

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

The worst your pain has been during the past 24 hours:

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Did your injury occur during:

☐ Routine/Household activity ☐ Work ☐ Sports/play ☐ Auto Accident

Date your condition/accident occured? (Month / Year)

Where did your injury occur?

Please explain what happened:

Are your symptoms currently:

☐ Staying about the same ☐ Getting Better ☐ Getting Worse

Is your condition interfering with your:

☐ Work ☐ Sleep ☐ Daily routine?

How has your condition interfered?

How are you currently able to sleep at night due to your symptoms?

☐ Sleep only with medication ☐ Awakened by pain ☐ Difficulty falling asleep ☐ No problem sleeping

Has this or something similar happened in the past?

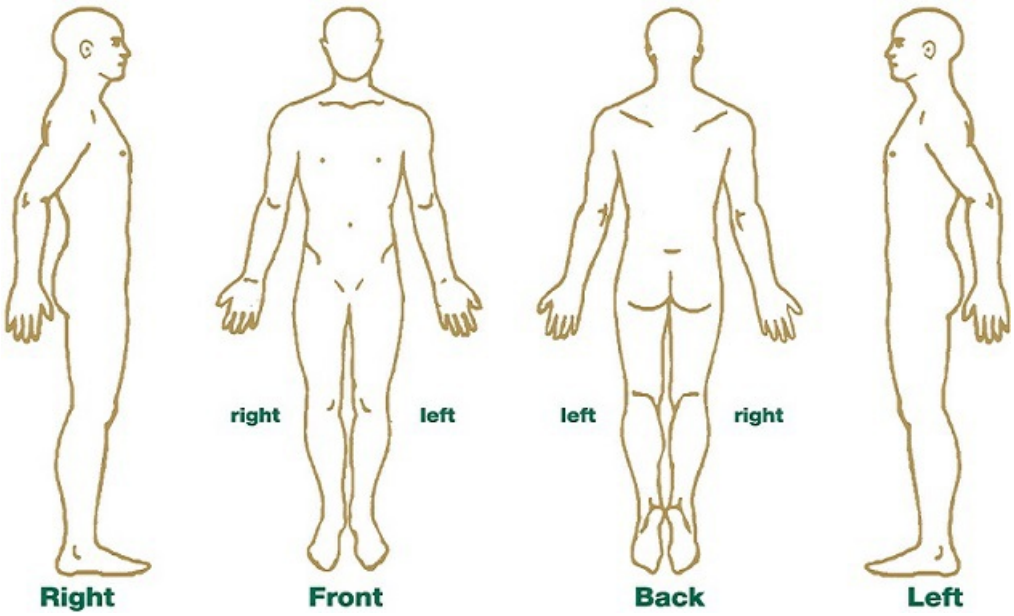
○ Yes ○ No

If you have experienced this problem in the past, when?

What treatment did you receive for this PAST problem?

How long did it take you to feel better?

What treatment do you think your symptom responded to best?



List three positions or activities that make your symptoms worse:

When do your symptoms feel worse?

☐ After exercise ☐ Night ☐ Evening ☐ Afternoon ☐ Morning

List three positions or activities that make your symptoms better:

When do your symptoms feel best?

☐ After exercise ☐ Night ☐ Evening ☐ Afternoon ☐ Morning

Are your symptoms currently:

○ Come and go ○ Are constant ○ Are constant, but change with activity

List treatments or tests performed for this problem: (Chiropracitc, Injections, X-rays, MRI, blood work, etc.)

Has condition been treated by a Medical Physician?

○ Yes ○ No

Medical Physician Contact Info

Has condition been treated by a Chiropractor?

○ Yes ○ No

Chiropractor Contact Information

Have you ever had physical therapy before?

○ Yes ○ No

If yes, please tell us the name of that practice.

Were you happy with your previous physical therapy experience?

○ Yes ○ No

6. MEDICAL INFORMATION

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killer(including aspirin) ☐ Muscle relaxers ☐ Blood Thinners ☐ Insulin ☐ Stimulants ☐ Other(s)

Please list any medications you are taking? (pills, injections, skin patches, over the counter)

Have you ever taken steroid medications for any medical conditions?

○ Yes ○ No

Have you ever taken blood thinning or anticoagulant medications for any conditions?

○ Yes ○ No

Please list any medications to which you may be allergic:

Have you RECENTLY noted any of the following (check all that apply)?

☐ Fatigue ☐ Headaches ☐ Changes in bladder function ☐ Changes in bowel function ☐ Falls ☐ Cough
☐ Difficulty swallowing ☐ Balance problems ☐ Fainting ☐ Heartburn/Indigestion ☐ Weight loss/gain
☐ Shortness of breath ☐ Dizziness/Lightheaded ☐ Nausea/Vomiting ☐ Diarrhea ☐ Muscle weakness
☐ Fever/Chills/Sweats ☐ Constipation ☐ Numbness or Tingling ☐ I don't have any of these problems

Do you have or have you EVER had any of the following diseases, medical conditions or procedures?

☐ Cancer ☐ Pacemaker ☐ Chest Pain/Angina ☐ Glaucoma ☐ Thyroid Problems ☐ Liver problems ☐ Heart Surgery
☐ Stroke ☐ Heart Attack ☐ HIV+ / AIDS / ARC ☐ Lung Problmes ☐ Pelvic inflammatory disease
☐ Bladder/urinary tract infection ☐ Other arthritic conditions ☐ Circulation problems ☐ Osteoporosis
☐ Multiple sclerosis ☐ Rheumatoid arthritis ☐ Bone or joint infection ☐ Pneumonia ☐ Blood clots ☐ Depression
☐ Sexually transmitted Disease ☐ Kidney Problems/Infection ☐ Arthritis ☐ Artificial Bones/Joints/Implants
☐ Lower Back Problems ☐ Chemotherapy ☐ Difficulty Breathing ☐ Tuberculosis ☐ Emphysema / Asthma
☐ Sinus Problems ☐ Fainting/Seizures/Epilepsy ☐ Ulcers / Colitisemia ☐ Severe / Frequent Headaches
☐ Rheumatic Fever ☐ Psychiatric Problems ☐ High/Low Blood Pressure ☐ Anemia ☐ Diabetes ☐ Frequent Neck Pain
☐ Eye problem/infection ☐ Shingles ☐ Congenital Heart Defect ☐ Mitral Valve Prolapse ☐ Artificial Valves
☐ Alcohol / Drug Abuse ☐ Hepatitis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

List any surgeries or other conditions for which you have been hospitalized, including dates. (For example: Appendectomy June 2008, Knee replacement July 2011 or enter none.)

Are you under doctor ordered work restriction? if so, explain.

Please list anything that you may be allergic to:

Are you latex sensitive?

○ Yes ○ No

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Not applicable ☐ Blood clots ☐ Depression ☐ High blood pressure ☐ Thyroid problems ☐ Stroke
☐ Heart problems ☐ Tuberculosis ☐ Diabetes ☐ Cancer

Do you take Supplements or Vitamins?

○ Yes ○ No

Do you exercise?

○ Yes ○ No

Hours per week

Do you smoke?

○ Yes ○ No

How much do you smoke?

How long have you smoked?

Are you wearing:

☐ Shoe lifts ☐ Inner soles ☐ Arch supports

Are you Pregnant?

○ Yes ○ No

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

○ I acknowledge my digital signature below.

Print your full name and sign:

X

Ip Address