LMT Rehabilitation Associates, P.C.

REGISTRATION FORM

Please print

Legal Name ____
Last First Middle Initial

Gender: M F Birth Date: ____________________ Last 4 Digits of Social Security # _________________

____
Street Address Apt# City State Zip Code + 4 digits

Primary Phone# (_______) _________________________ Circle One: Home Cell Work

Alternate Phone # (_______) ________________________ Circle One: Home Cell Work

May we leave a message at the above phone number(s) containing your medical information? No Yes

Marital Status (Please Circle One): Single Married Divorced Separated Widowed

Race: (Please Check)
- □ American Indian or Alaska Native
- □ Asian
- □ African American
- □ More than one race
- □ Native Hawaiian
- □ Other Pacific Islander
- □ White
- □ Refuse

Ethnicity: (Please Check)
- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Refuse

Primary Language Spoken: _________________________

Employment Status (Please Circle One): Student Full-time Part-time Retired

____
Name of Employer/Company Phone#

Who referred you for today's appointment? Physician Hospital Friend/Relative Self Website P.T. Other___________

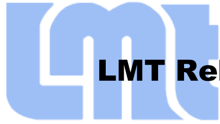
____
Referring Physician's Name Phone #

EMERGENCY CONTACT INFORMATION

____
NAME OF EMERGENCY CONTACT PHONE #

______________________ Do you want your Medical Health Record or Billing information shared with this person? Yes No
Relationship to Patient

PLEASE FILL IN ALL INSURANCE AND BILLING INFORMATION ON PAGE 2



LMT Rehabilitation Associates, P.C.

Primary Insurance Company Name: ____

Subscriber's Name ______________________________________ Birth date: _____________

Contract ID# ______________________________________ Group # __________________

Subscriber's Relationship to Patient: Self Spouse Minor-Child Adult-Child Other ________________

Secondary Insurance Company Name: ____

Subscriber's Name ______________________________________ Birth date: _____________

Contract ID# ______________________________________ Group # __________________

Subscriber's Relationship to Patient: Self Spouse Minor-Child Adult-Child Other ________________

OPEN AUTO/ WORK COMP/ LIABILITY CLAIM BILLING INFORMATION:

Is Auto your Primary Insurance? Yes No
Do you have an Open Claim Letter from your insurance company or adjuster? (required at time of service) Yes No

Do you have an authorization or Open Claim Letter from your Work Comp. or Liability Carrier? (required at time of service) Yes No

Please complete additional Workman's Compensation or Auto Claim form/questionnaire

Insurance Co. Name: ___________________________ **Circle Type**: Auto Work Comp. Liability

Claim# ____________________________________ **Date of Injury**: __________________

Claim Adjuster's Name: ___________________________ **Phone#**: ____________________

Billing Address: ____
P.O. Box/Address City State Zip Code

Is there an attorney involved in your case? Yes No ____
Attorney Name Phone#

I consent to all treatment as necessary or desirable to the care of the patient named above. This is not restricted or limited to whatever drugs, medicine, laboratory, x-rays, or other studies that may be used by the attending physician or one of his/her nurse or qualified delegates. I am aware of LMT's HIPAA privacy policy and procedures, and understand that a copy will be provided to me at my request. By signing below, I understand that all professional services rendered will be my financial responsibility. I give permission to LMT to bill my insurance company and I will be responsible for any unpaid balances, co-pays, and deductibles. I agree to pay for these services by cash, check, money order, Visa, Master Card, American Express, or Discover Card.

____
PATIENT / GUARDIAN SIGNATURE DATE

LMT Rehabilitation Associates, P.C.

Current Medications

Patient Name ________________________________ Today's Date ________

Preferred Pharmacy Name & City _______________________________________

Pharmacy Phone __________________

Medications	Strength	Directions

MA's Initials ________

MRN# _______________________
(Office Use Only)

LMT Rehabilitation Associates, P.C.

Medical history:

- ☐ Alcohol dependency
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthetic reaction
- ☐ Angina/chest pain
- ☐ Arthritis
  Location______________
- ☐ Asthma
- ☐ Bleeding problem
- ☐ Cancer
  Type _______________
- ☐ Cerebral Palsy
- ☐ Closed head injury
- ☐ Colon polyps
- ☐ COPD
- ☐ Coronary artery disease
- ☐ CVA/Stroke
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Drug dependency
- ☐ GERD/Acid reflux
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Hyperlipidemia
- ☐ Hypertension/High blood pressure
- ☐ Hypoglycemia
- ☐ Kidney problems
  Type______________________
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Peripheral arterial disease
- ☐ Phlebitis (blood clots)
- ☐ Pregnant
- ☐ Seizures/convulsions
- ☐ Ulcer
  Type/location________________
- ☐ Other ______________________

Surgical history:

- ☐ Angioplasty
- ☐ Aortic valve replacement
- ☐ Appendectomy (appendix removal)
- ☐ Carpal Tunnel release
- ☐ C Section
- ☐ CABG (coronary artery bypass)
- ☐ Cataract Removal
- ☐ Cholecystectomy (gall bladder removal)
- ☐ Colectomy
- ☐ D & C
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Scope (Arthroscopy)
  Location____________
- ☐ Joint Replacement (Arthroplasty)
  Type:______________
- ☐ Lumpectomy
- ☐ Mastectomy
  Side_______________
- ☐ Splenectomy
- ☐ Spine surgery:
  Type: ______________________
- ☐ Tonsils/Adenoids
- ☐ Tubal Ligation
- ☐ Other ______________________