# *NEW PATIENT REGISTRATION FORM*

Patient's Full Name______________________________________________
Last First Middle Initial

Street Address______________________________________________
City State Zip

Mailing Address______________________________________________
City State Zip

Home Phone______________________ Work Phone______________________

Cell Phone ______________________ Date of Birth______________________

Sex ☐ Male ☐ Female ☐ Other **Date of Injury**______________________

Patient Marital Status: ☐Single ☐Married ☐Widowed ☐ Divorced ☐Other

**EMAIL ADDRESS**______________________________________________
**[] I consent to receive emails from Strive!** **[] I DO NOT consent to receive emails from Strive!**

**☐Work Comp Claim** **☐Auto Claim, State**__________ **☐Attorney**______________________

**Are you currently receiving ANY Home Health Services** ☐ **Yes** ☐ **No**

**Employer / Company at time of injury:**

Name______________________________Phone#:______________________

Street Address______________________________________________
City State Zip

**WHO MAY WE CONTACT IN CASE OF EMERGENCY?**

Name______________________ Phone Number______________________
Relationship______________________

**INSURANCE INFORMATION** (check one please) ☐ MC ☐ Tricare/Champus ☐ Auto ☐ BC/BS
☐ WC ☐ Medicaid ☐ Commercial ☐ UHC

Subscriber's Name If different than patient______________________DOB______________

Insurance Name______________________________________________
Subscriber's Number______________________ Group Number______________________
Employer Name______________________________________________
Street Address______________________________________________
City State Zip

Secondary Insurance______________________________________________

**AUTHORIZATION FOR TREATMENT**

I authorize Strive! Health and Rehabilitation, its employees and agents as well as any and all independent contractors engaged by Strive! Health and Rehabilitation to perform the services on my behalf as they may deem necessary.
I have authorized direct payment from my insurance plan to Strive!

Signature______________________________ Date______________________

# AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We feel strongly that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

## PLEASE READ AND INITIAL THE FOLLOWING:

_______ I authorize this office to release or receive any information necessary to expedite insurance claims.

_______ I hereby authorize this office to bill my insurance company directly for their services

_______ I authorize payment directly to this provider of my insurance benefits otherwise payable to me

_______ In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable

_______ I hereby authorize the Strive! Health and Rehabilitation physical and occupational therapist (s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize Strive! Health and Rehabilitation to perform any service (evaluation, treatment procedures, and testing) necessary for my rehabilitation

_______ Strive! Health and Rehabilitation is granted permission to release to the insurance carrier, employer, attorney, their representatives or referring physician, any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.

_______ **HIPAA**: I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I understand that I am directly and completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee.

A Photostat copy of these authorizations and agreements shall be as valid as the original.

| ______________________ | ______________________ | __________ |
|---|---|---|
| Patient or Guardian (print) | Patient or Guardian (signature) | Date |

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

| DATE | INJURY | DATE | INJURY |
|---|---|---|---|
| ______ | ______________________________ | ______ | ______________________________ |
| ______ | ______________________________ | ______ | ______________________________ |

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Kidney disease
YES NO Alcoholism (chemical dependency)

YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Other______________________

For Office Use

Please list any **PRESCRIPTION** medication you are currently taking (INCLUDING pills, injections, and/or skin patches/cream):

1.____________________ 2.____________________ 3.____________________

4.____________________ 5.____________________ 6.____________________

How much caffeinated coffee or caffeine containing beverages do you drink per day? ____________________

How many packs of cigarettes do you smoke a day? ____________

How many days per week do you drink alcohol? ______________

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ________________

Have you recently noted:

YES NO Weight loss/gain
YES NO Nausea/vomiting
YES NO Fatigue
YES NO Weakness
YES NO Fever/chills/sweats
YES NO Numbness or tingling

For Office Use

______________________________ ______________________
**Signature** **Date**

______________________________ ______________________
**Therapist Signature** **Date**

**Strive!**
HEALTH & REHABILITATION

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. ***Thank you!***

Name:______________________________ Leisure Activities:______________________

Age:______________________ Occupation:______________________________

**ALLERGIES:** List any medication(s) you are allergic to:______________________

Are you latex sensitive? Yes No List any other allergies we should know about:______________________

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Do you have a pacemaker? Yes No

Please check ( √ ) any of the following whose care you're under

___Medical doctor ( MD ) ___Psychiatrist/Psychologist Other__________________
___Osteopath ___Physical Therapist __________________
___Dentist ___Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc...)

______________________________________________________________

______________________________________________________________

Have you **EVER** been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:__________________
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical Dependency (i.e. alcoholism)
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Other Arthritic Conditions
YES NO Depression
YES NO Infections (positive blood test for Hepatitis, HIV, AIDS)
YES NO Tuberculosis
YES NO Stroke, TIA
YES NO Kidney Disease
YES NO Anemia
YES NO Epilepsy
YES NO Other

For Office Use

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

| | DATE | REASON FOR SURGERY/HOSPITALIZATION |
|---|---|---|
| 1. | ______ | ______________________ |
| 2. | ______ | ______________________ |
| 3. | ______ | ______________________ |
| 4. | ______ | ______________________ |

**OVER→**

# How did you hear about us?

**PLEASE BE AS SPECIFIC AS POSSIBLE…….**

**Doctor** ______________________

**Friend/Relative** ______________________

**Previous Patient** ______________________

**Advertisement (ex: magazine, directory)** ____________

**Website** ______________________

**Internet (ex: Google search)** ______________________

**Social Media (ex: Facebook, Twitter)**________________

**Brochure** ______________________

**Event (ex: healthfair, community event, presentation)**
______________________________________

**Phone Book** ______________________

**Employee** ______________________________

**Other** ____________________________________