REGISTRATION FORM

Today's Date ___ /____ /____ Auto Accident? ☐Yes ☐No

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth Date / /	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security	Preferred Phone No. ( )

Date of onset/problem / /	Occupation	Employer	Employer Phone No. ( )

How did you hear about us? (Please Check one Box) ☐ Dr_____ ☐ Ins Plan ☐ Hospital

☐ Family/Friend ☐ Returning Patient ☐ Close to Home/Work ☐ Internet Search ☐ Other_____

May we contact you via email? ☐ Yes ☐ No *if yes*, email address:_____

How would you like to receive appointment reminders? ☐ Email ☐ Text ☐ Call # (____)_____

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No	Name of Primary Insurance				
Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here? ☐ Yes ☐ No			

Occupation	Employer	Employer Address	Employer Phone No. ( )

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Do you have an attorney for this injury? ☐ Yes ☐ No

Attorney's Name: _____ Address: _____ Phone No. ( )

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to *Primus Physical Therapy, LLC*. I understand that I am financially responsible for any balance. I also authorize *Primus Physical Therapy, LLC* or insurance company to release any information required to process my claims.

Signature: _____ Date:_____

6101 Redwood Square • Suite 202 • Centreville, VA 20121
703.543.6660 • info@primuspt.com • www.primuspt.com

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____, have received the Notice of Privacy Practices from Primus Physical Therapy.
(print your name)

X_____ Date _____
(Signature)

In lieu of patient signature, I,_____, a staff member of Primus Physical Therapy
(for PrimusPT use only)
state that_____has been given our current Notice of Privacy Practices.
(print patient name)

X_____ Date _____
(for PrimusPT use only)

Discussion of Treatment/Medical Information

A. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? Yes_____No _____

B. Is there any individual, besides your doctor and involved health care practitioner(s), with whom Primus Physical Therapy has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name:

Spouse/Significant Other	Y_____N_____	_____
Son/Daughter	Y_____N_____	_____
Son-in-law/Daughter-in-law	Y_____N_____	_____
Friend	Y_____N_____	_____
Other	Y_____N_____	_____

Place of Treatment

To facilitate your care, a portion of your treatment may take place in the open gym area of our clinic. Do you agree to this? Yes____ No____

Additional Medical History

Patient Name: _____

List Medications

Name of Medication	Dosage	Amount	How Often

Over the Counter Medications (check all you take regularly)

□ Aspirin/Ibuprofen □ Cold Medicine □ Laxative □ Other _____
□ Antacids □ Cough Medicine □ Diet Pills □ Other _____
□ Sleeping aids □ Allergy Relief □ Vitamin/Herbal supplements

Do you wear glasses / Contacts? ☐Yes ☐No

Have you fallen in the past year? ☐Yes ☐No
If yes, how many times: _____
If yes, did you sustain an injury as result of the fall? ☐Yes ☐No

Do you currently have any "flu-type" symptoms (i.e. fever, coughing)? ☐Yes ☐No
If yes, what symptoms: _____

Do you have any open cuts, lesions or wounds? ☐Yes ☐No
If yes, where: _____

_____ _____
Patient Signature Date