KEITH PHYSICAL THERAPY REGISTRATION FORM

5700 NW 132nd St Okla. City Okla. 73142 Phone: 405-843-5710

Today's date:	Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single Mar Div Sep Wid

Ethinicity W___ African American:____ Asian:__	Hispanic or latino____ Other:____		Birth date:	Age:	Sex: ❑ M ❑ F

Address:	Social Security no.:	Home phone no.: ( ) Mobile: ( )

City	State:	Zip Code:	

Occupation:		Employer phone no.: ( )

Email:

INSURANCE INFORMATION

Do Not complete if card is given to receptionist

Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	CONTACT PHONE: ( )	Work phone no.: ( )

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

PATIENT SIGNATURE: DATE:

KEITH PHYSICAL THERAPY 5700 NW 132nd St Okla.City,Ok. 73142

Name:_____ Weight:_____ Height:_____ Today's Date:_____

Occupation:_____ Full-time_____ Part-time_____

Do you currently have or have had any of the following?

High Blood Pressure	☐Yes	☐No	Dizziness	☐Yes	☐No
Pacemaker	☐Yes	☐No	Visual Disturbances	☐Yes	☐No
Cancer	☐Yes	☐No	Difficulty Swallowing	☐Yes	☐No
Diabetes	☐Yes	☐No	Nausea/Vomiting	☐Yes	☐No
Stroke/TIA	☐Yes	☐No	Headaches	☐Yes	☐No
Lung Disease/COPD	☐Yes	☐No	Unexplained Weight Changes	☐Yes	☐No
Osteoporosis	☐Yes	☐No	Recent Fever/Chills/Sweats	☐Yes	☐No
Osteoarthritis	☐Yes	☐No	Bowel/Bladder Changes	☐Yes	☐No
Rheumatoid Arthritis	☐Yes	☐No	Sleep Interruption From Pain	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Cough	☐Yes	☐No
Pregnancy	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Thyroid Disease	☐Yes	☐No	Chest Pain	☐Yes	☐No
Kidney Disease	☐Yes	☐No	Hearing Changes	☐Yes	☐No
Blood Thinners	☐Yes	☐No	Depression	☐Yes	☐No
Stomach Ulcers	☐Yes	☐No			
Blood Clots	☐Yes	☐No	**Social History:**		
Autoimmune Disease	☐Yes	☐No	Do you drink alcoholic beverages?	☐Yes	☐No How much_____
Hepatitis/HIV	☐Yes	☐No	Do you use tobacco?	☐Yes	☐No How Much_____

Any history of Falls within the last 12 months? Yes_____ NO_____

Other Medical Illnesses not listed above_____

Current Medications (including prescription, over-the-counter and herbal):_____

_____

Allergies (include medications, latex, etc.):_____

_____

Describe your most severe current complaint(s) and limitations and when they began: _____

_____

Have you ever had this problem before and if so what treatment helped the most?_____

_____

List of previous hospitalization/surgeries with approximate dates_____

_____

List dates and results of any: Xrays_____

MRI:_____

Bone Sensity Test:_____

Other Tests:_____

Describe your pain today: Deep ____ On the surface_____ Getting better_____ Worse_____Staying Same_____
Are symptoms worse in the _____AM ____Afternoon _____Night Stays The same all the time_____
What worsens the pain?_____ Makes it better?_____

On a scale of 1-10(0= no pain, 10= worst pain imaginable)
Current pain today_____ Worst its been_____ Best its been_____

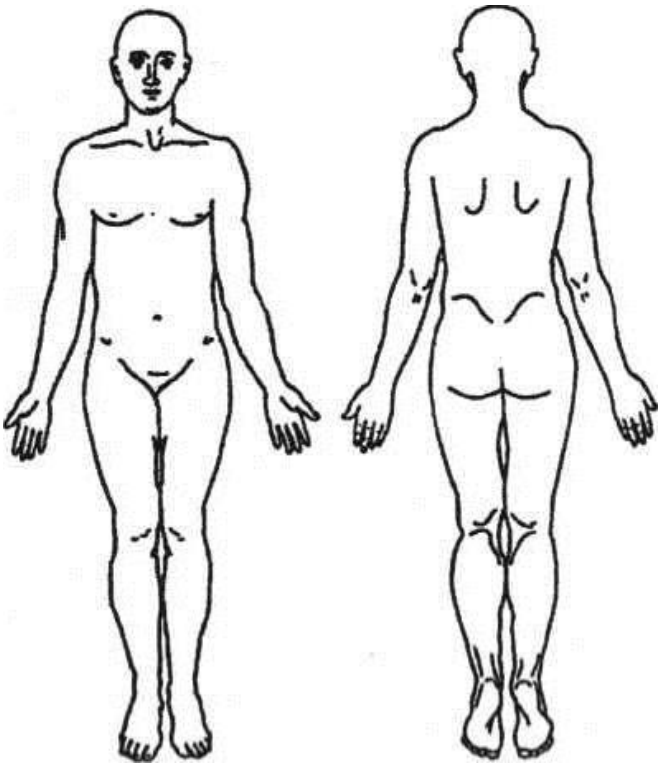
Do you have any regular numbness or tingling? Yes_____ No_____

Have you been able to sleep at night? Yes____ No_____

Using the diagrams below please indicate where you feel your symptoms: Using this key to indicate the different types

Of symptoms: Pins and needles 000000 Burning XXXXXX Throbbing +++++++

Sharp/Stabbing ////// Deep Ache ZZZZZZ



Patient Signature:_____Date:_____

Keith Physical Therapy

Cancellation / No Show Policy

Cancellation/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance there will be a twenty-five dollar ($25) fee; this will not be covered by your medical insurance company or workers compensation coverage. You will be responsible for this charge.

Sign: _____ Date:_____

Policy Regarding Late Appointments

Scheduled Appointments

We understand that delays can happen however, we must try to keep other scheduled patients and the therapist on time.

Therefore, patients who arrive 20 minutes after their scheduled time, may have to reschedule their appointment.

Sign: _____ Date:_____

KEITH PHYSICAL THERAPY INC

5700 NW 132nd St Oklahoma City, Oklahoma 73142 405-843-5710

HIPPA requires us by law to maintain the privacy of your personal health information and to have a written policy stating how your information is protected and how we use your personal health information.

Our office has a privacy policy which outlines what we can and cannot do with your health information. You will be provided with a copy of our privacy policy if requested.

I would like to have a copy of your privacy policy. Yes_____ No_____

Patient Signature:_____Date_____