

Patient Registration



Patient Info:

Your Full Name: _____ DOB: _____ Gender: M F
Mailing Address: _____ City: _____ State: _____ ZIP: _____
Home Phone: () _____ Alternative: () _____
Email Address: _____
Emergency Contact Person: _____ Phone: () _____
My condition is related to: Work Auto Accident Other: _____
Social Security #: _____ Marital Status: _____
Occupation: _____ Work Status: Currently Employed Student Retired Disabled
Employer Name: _____ Employer Address: _____
Employer Phone: () _____
How did you hear about us? _____

Medical History:

Please check any boxes that apply to your health history to help us ensure your safety with treatment:

- | | | |
|--|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizures/Stroke | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Chest Pain/ Angina |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Other: _____ |

Surgical History: _____

Please list any medications you are currently taking: _____

Payment Info:

NON-CASH Payers:

- I have insurance and would like you to deal directly with them. I will assign my benefits over to you.
- I was injured on the job and my employer's insurance will be paying the bills.
The insurance company is: _____ Claim #: _____
- I was injured in a car accident.
The insurance company is: _____ Claim #: _____

CASH Payers:

- I am paying out of pocket for services. Please give me a 30% discount.
- I have insurance but want the 30% discount by paying up front. (Good if you have a high deductible)
- I have an attorney but want the 30% discount by paying up front. I'll get reimbursed after my case settles.

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I also understand that I am responsible for all copays, deductibles, and portions of my bill not covered by my insurance company or denied by Workman's Compensation. I certify that I and/or my dependents have insurance as stated above, and assign benefits directly to Therapy Masters, LLC.

Signature of Patient or Guardian: _____ Date: _____