Connellsville
171 W Crawford Avenue
(724) 628-7288
Fax: (724) 628-7299

Scottdale
109 Crossroads Road
(724) 887-4181
Fax: (724) 887-4183

PATIENT REGISTRATION FORM

Patient Information

First Name	
Middle Name	
Last Name	
Nickname	
Gender	
Date of Birth	
Marital Status	

Address

Street	
City	
State	
Zip Code	

Contact

Email Address			
Home Phone			
Mobile Phone			
Emergency Contact	Name:	Phone:	Relationship:

Identifications

Social Security Number				
Driver License Number		Effective Date:	Expiration Date:	Issuing State:
Employer Name				

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KING PHYSICAL THERAPY & FITNESS - PAST MEDICAL HISTORY FORM

Check which apply to your symptoms:

- ☐ work related injury
- ☐ motor vehicle accident
- ☐ recurrence of previous injury
- ☐ injury related to lifting
- ☐ injury related to falling
- ☐ athletic/recreational injury
- ☐ cause unknown
- ☐ other: _____

Are you presently working? Yes___ No___ Date of next physician's visit: _____ Date of injury/onset: _____

Have you ever had these symptoms before? Yes ___ No ___ Have you had a related surgery? Yes___ No___

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

Yes	No		Yes	No	
___	___	Diabetes	___	___	Allergies/Poor tolerance to Cold
___	___	Chest Pain/Angina	___	___	Other Allergies
___	___	High Blood Pressure	___	___	Hernia
___	___	Heart Disease	___	___	Seizures
___	___	Heart Palpitations	___	___	Metal Implants
___	___	Pacemaker	___	___	Dizziness/Fainting
___	___	Headaches	___	___	Recent Fractures
___	___	Kidney Problems	___	___	Surgeries
___	___	Are you pregnant?	___	___	Skin Abnormalities
___	___	Cancer	___	___	Sexual Dysfunctions
___	___	Osteoporosis	___	___	Nausea/Vomiting
___	___	Bowel/Bladder Abnormalities	___	___	Ringing in your ears
___	___	Urine Leakage	___	___	Rheumatoid Arthritis
___	___	Asthma/Breathing Difficulties	___	___	Special Diet Guidelines
___	___	Liver/Gallbladder Problems	___	___	Hypoglycemia
___	___	Smoking	___	___	Stroke/CVA
___	___	Allergies to Aspirin	___	___	Depression or Anxiety
___	___	Allergies to Heat	___	___	Other_____

If yes on any of the above, please briefly explain and give approximated date:

_____

_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

Are you presently taking Medication? Yes___ No___ If yes, please list what medications and for what condition:

_____

_____

Do you perform moderately intense exercise 3 times per week? Yes___ No___

Height_____ Weight_____

Patient's Signature	Date	Signature of Guardian, if Minor	Date
Patient Printed Name		Therapist's Signature	Date

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Consent and Statement of Financial Responsibility

I hereby consent to the use and disclosure of my health information for treatment provided to me by **King Physical Therapy**, payment for services provided by the provider or other health care providers and the operations of **King Physical Therapy** and others under certain circumstances. I understand that a more detailed explanation of the ways **King Physical Therapy** may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

CONSENT FOR TREATMENT _____ *Initial Here*

It is our goal to provide the highest quality of care in a safe environment, in which patients may receive treatment, and staff may carry out their professional responsibilities to patients. In our efforts to achieve this goal, we require all patients, accompanying family members, and visitors to refrain from any disruptive behavior, which may pose a threat to the rights or safety of other patients and employees. Accordingly, our patients agree to refrain from the following actions: (1) Bringing firearms or other weapons into the clinic; (2) Inappropriate behavior involving alcohol/substance use at time of treatment; (3) Attempting to intimidate or harass in any manner therapists, staff, or fellow patients; (4) Inappropriately touching therapists, staff, or fellow patients; (5) Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality; (6) Making harassing, offensive or intimidating statements, or threats of violence through any medium of communication; (7) Making verbal threats to harm another individual or destroy property; (8) Physical assault or inflicting bodily harm; and (9) Intentionally damaging equipment or property. Violators of the abovementioned actions may be asked to leave the facility and/or be discharged from the clinic. Our patients have the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual orientation, or national origin. My signature below indicates that I will support the clinic in its efforts to provide me with quality care in a safe environment and that I understand and accept the terms of the Patient Code of Conduct.

FINANCIAL CONSENT AND ASSIGNMENT OF BENEFITS _____ *Initial Here*

I hereby authorize **King Physical Therapy** and any subsidiary to administer treatment required for my diagnosis and to apply for benefits from my insurance carrier(s). I assign payment for the medical benefits directly to **King Physical Therapy**. I agree to pay **King Physical Therapy** for services and supplies according to its regular rates and charges at the time these services and supplies are rendered. **I understand that I am responsible for any health insurance deductibles, co-insurance, co-pays, and any amounts not paid by my insurance carrier. I also understand that it is my responsibility to know my insurance benefits and coverage limitations.** If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by **King Physical Therapy** in collecting this account.

My signature below indicates that I understand the terms of treatment by King Physical Therapy.

Print Patient/Guardian Name Signature Date