ACT PHYSICAL THERAPY

3532 Vann Rd, Suite 102
Trussville, AL 35235

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

________________________ ________________________ ______________
Last name First name Middle initial

Address: ____

________________ ________________ ______________
City State Zip

Phone: ____________________ Work: ______________ Cell: ______________

EMPLOYMENT INFORMATION

Name: ____

Address: ____

________________ ________________ ______________
City State Zip

Phone: ____________________ Extension: ______________

EMERGENCY CONTACT INFORMATION

________________________ ________________________ ______________
Name of contact Relationship to patient Phone

Address: ____

________________ ________________ ______________
City State Zip

ADDITIONAL PATIENT INFORMATION

Sex: Male _____Female ______ Race: ___________ Marital Status: Single_______ Married______ Other______

Date of Birth: ______________ WT: __________ HT: __________ Last 4 digits SS#____________

Referring Physician: ____________________ Diagnosis: ____________________

Allergies: ____

Current medications (Please list all even Advil)

____

____

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____

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Surgical History (Please list all surgeries to date)

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____

Current medical conditions (High Blood Pressure, Diabetes, Cancer etc.)

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____

____

Did you have an accident or injury? **YES / NO** Date of accident: ____________________________

If yes, please explain:

____

____

____

Is this a work related injury? **YES / NO**

In the past have you ever been treated at ACT Physical Therapy? YES / NO

If, so which Location: ______________________

MEDICARE PATIENTS ONLY

Have you in the current calendar year been treated by Home Health or Outpatient therapy? **YES / NO**

______Physical Therapy **_______Occupational Therapy** **_______Speech Therapy**

If, so how visits many _______

PLEASE SIGN BELOW TO AUTHORIZE INSURANCE BILLING

I authorize that payment by my Insurance Company be made directly to **ACT Physical Therapy** on my behalf for services furnished to me. I authorize the release of any medical information about me to the Health Care Financing Administration and its agents and any information to determine benefits payable for related services. I further recognize that if the insurance company makes payment directly to me, the amount received is the property of **ACT Physical Therapy** and its agents to render treatment to me as deemed appropriate and as prescribed by my physician.

SIGNATURE: ____ DATE: ______________________