8907 Shady Grove Court
Gaithersburg, Maryland 20877
T 301-921-9818 **F** 301-921-0719
www.shadygrovept.com

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Last name:	First:	M.I.:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email Address:	Preferred method of contact: ❑ Cell ❑ Home ❑Email	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell Phone no: ( )	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

INSURANCE INFORMATION

Please indicate primary insurance	❑ MEDICARE	❑ BCBS	❑ UHC	❑ AETNA	❑ CIGNA

❑ AUTO ACCIDENT	❑ ALLIANCE/M.D.IPA	❑ SELF PAY	❑ WORKMAN'S COMP/LIABILITY	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

AUTHORIZATION

I hereby authorize the Physical Therapists of Shady Grove Physical Therapy and Rehab Center to examine, treat, and prescribe any medical equipment that would benefit my health and help to relieve my symptoms. I agree to **pay for all charges** for services, medications, and products received **at the time of service**. If for any reason a balance is not paid at the time of service, I agree to pay the balance due plus all billing, collection, and attorney fees that are incurred in the attempt to collect that debt.

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	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 Shady Grove Physical Therapy & Rehab Center. I understand that I am financially responsible for any balance. I also authorize Shady Grove Physical Therapy & Rehab Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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& REHAB CENTER

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PATIENT QUESTIONNAIRE

Your insurance company **requires** that we obtain this information. Please fill it out as thoroughly as possible as this will assist your physical therapist in developing a diagnosis and plan of care!

PATIENT'S NAME: ______________________________**AGE:** ______ **DATE OF BIRTH:** _________________

REFERRING PHYSICIAN: ___________________________________ **DATE OF ONSET:** _________________

MEDICAL HISTORY: Please circle if you have, or have had, any of the following: ☐ NONE

1. Diabetes	4. Heart Arrhythmia	7. Heart Attack	10. Rheumatoid Arthritis	13. Stomach/Duodenal
2. Stroke/TIA	5. Coronary Heart Disease	8. High Cholesterol	11. Liver Disease	14. Gastro/Esoph/Acid Reflux
3. Osteoarthritis	6. High Blood Pressure	9. Depression	12. Kidney Disease	15. Cancer (type)__________

OTHER____

IF FEMALE: IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT? ☐ Yes ☐ No

SURGICAL PROCEDURES: Have you ever had any surgery? ☐ YES ☐ NO If yes, please circle:

1. Heart Surgery	3. Vascular Bypass	5. Angioplasty	7. Appendectomy	9. Carotid Endarterectomy
2. Hernia Repair	4. Hysterectomy	6. Cancer Surgery_______	8. Gallbladder Surgery	Date of Surgery:________

Please list any ***orthopaedic surgeries*** you have had: ____

OCCUPATION: ____

SOCIAL HISTORY:
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No

MEDICATIONS: Do you take any medications, including aspirin and other non-prescription medications? ☐ Yes ☐ No
If yes, please list: ____

ALLERGIES: Are you allergic to any medications, environmental substances, or metals? ☐ Yes ☐ No
If yes, please list. ____

WHAT PART OF THE BODY ARE YOU HERE FOR TODAY? _________________ ☐ **LEFT** ☐ **RIGHT**

WHEN DID THIS PROBLEM BEGIN?*____
*IF ONGOING, PLEASE INDICATE TIME PERIOD OF MOST RECENT EPISODE OR "FLARE-UP:"
____

WAS THERE A SPECIFIC INJURY? ☐ Yes ☐ No **If yes, briefly describe incident:**
HOME, WORK, AUTO ACCIDENT, OTHER

PAST HISTORY – Have you had previous problems with this area? ☐ Yes ☐ No If yes, please describe:
____

HAVE YOU EVER SEEN A PHYSICAL THERAPIST FOR THIS PROBLEM? ☐ Yes ☐ No
If so, when? ________________

WERE X-RAYS TAKEN? ☐ Yes ☐ No
WERE ANY OTHER TESTS PERFORMED FOR THIS PROBLEM? ☐ Yes ☐ No
If yes, please list: .____

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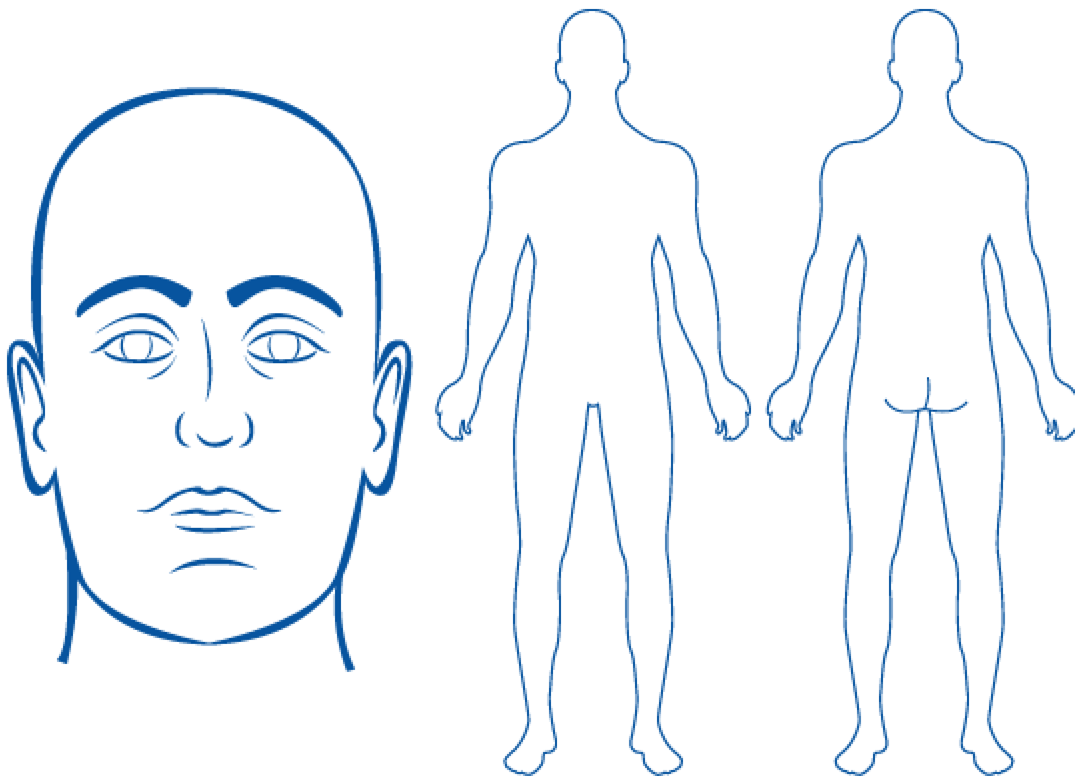
PLEASE INDICATE WHERE YOUR PAIN IS ON THE DIAGRAM BELOW: MARK PAIN WITH AN ‘**X**’, MARK NUMBNESS WITH **‘**/\/\/\ ‘, MARK TINGLING WITH ‘**O**’



The above is true and correct to the best of my knowledge.

PATIENT SIGNATURE ____ DATE ___________________

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24 Hour Appointment Cancellation Policy

Shady Grove Physical Therapy and Rehabilitation Center has a 24 hour cancellation / rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged a $30.00 cancellation fee.

Insurance companies do not cover this fee.

This policy has been created in respect to our therapists and other patients. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot that really needs it.

By signing below, you acknowledge that you have read and understand our Cancellation Policy for Shady Grove Physical Therapy and Rehabilitation Center.

Thank you for your understanding and cooperation with our policy.

Printed Name: ______________________________

Signature: ___________________________ Date: __________________

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Shady Grove Physical Therapy and Rehab Center

Acknowledgement of Receipt of Privacy Practices Notice
*A copy of The Privacy Practice Notice is available to you at the office per your request. In short, this notice states that our healthcare staff will respect and maintain your privacy as a patient of our office.

Section A: The Patient

Name: ____

Address: ____

Telephone: ______________________ E-mail_______________________________

Social Security Number: ______________________________

Section B: Acknowledgement of Receipt of Privacy Practices Notice.

I, ____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _______________________________Date_________________________
If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name____

Relationship to Individual: ____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt.
Describe your good faith effort to obtain the individual's signature on this form: ____

____

SIGNATURE:
I attest that the above is correct.

Signature:_________________________________ Date: _____________________

Print name:________________________________ Title: _____________________