PATIENT REGISTRATION

SYNERGY
REHABILITATION AND WELLNESS CENTER

Patient Information *(please print)*				
PATIENT NAME (last, first, middle)	SOCIAL SECURITY #	SEX: ☐ M ☐ F	DATE OF BIRTH	AGE
ADDRESS	CITY / STATE / ZIP CODE		RACE/ETHNICITY	
HOME PHONE # ( )	CELL PHONE # ( )	WORK PHONE # ( )	PRIMARY LANGUAGE	
MARITAL STATUS: ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	EMAIL ADDRESS MAY WE CONTACT YOU BY EMAIL: ☐ YES ☐ NO			
EMPLOYER/OCCUPATION			EMPLOYMENT STATUS: ☐ PART-TIME ☐ FULL-TIME	
REFERRED TO CLINIC BY: ☐ PHYSICIAN ☐ FAMILY ☐ FRIEND ☐ CLOSE TO HOME/WORK ☐ INTERNET ☐ OTHER: _____				

Emergency Contact			
NAME *(last, first, middle)*	RELATIONSHIP	HOME PHONE # ( )	WORK PHONE # ( )

Financial Guarantor (responsible party)			
NAME OF FINANCIAL GUARANTOR *(responsible party)*	SOCIAL SECURTIY #	SEX: ☐ M ☐ F	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP CODE		RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER
HOME PHONE # ( )	CELL/WORK PHONE # ( )		
EMPLOYER	EMPLOYER ADDRESS		

Primary & Secondary Insurance				
PRIMARY INSURANCE NAME	SUBSCRIBER NAME		DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE:
SECONDARY INSURANCE NAME	SUBSCRIBER NAME		DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE:

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

Authorization for release of information
I authorize SYNERGY REHABILIATION AND WELLNESS CENTER to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits and financial responsibility
I authorize the assignment of benefits payable to SYNERGY REHABILIATION AND WELLNESS CENTER and/or its designee for physician services and supplies by government and/or other private third-party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services. I understand this office does not guarantee that my insurance company will pay for treatment I receive from this practice. They will perform routine insurance billing procedures upon verification of coverage. However, if my claim is denied, I will be responsible for paying the full amount at that time. This office will not enter into a dispute with my insurance company over any claim, although they will provide the necessary documentation my insurance company requests to clarify any confusion or questions that may arise. This office will fully cooperate with the regulations and requests of my insurance company. I understand that it is ultimate my responsibility to resolve any type of dispute over payments made or not made by my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company.

Authorization for additional fees
In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment
I agree to any examination, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice
By signing below, I agree that I have received a copy of the **Notice of Privacy Practices for Protected Health Information.**

X_____|_____
SIGNATURE (Parent or Legal Guardian, if minor) DATE

NEW PATIENT INFORMATION

SYNERGY
REHABILITATION AND WELLNESS CENTER

DATE _____

_____ _____ _____ _____
LAST NAME FIRST NAME DATE OF BIRTH AGE

_____
PHARMACY NAME PHARMACY PHONE NUMBER:

_____
PRIMARY CARE PHYSICIAN PHONE NUMBER

_____
REFERRING PHYSICIAN PHONE NUMBER

Sex: ☐ Male ☐ Female Dominant hand: ☐ Left Handed ☐ Right Handed

CHIEF COMPLAINT

Reason for visit: _____

Location of your pain:

☐ Head ☐ Neck ☐ Mid Back ☐ Wrist/Hand ☐ Hip/Buttocks ☐ Leg
☐ Headaches ☐ Shoulder ☐ Low Back ☐ Arm ☐ Knee ☐ Ankle/Foot

HISTORY OF PRESENT ILLNESS

Date of injury or symptom onset: _____ Type of injury: ☐ Sports Injury ☐ Job Accident ☐ Other (explain): _____

Please describe how you injured yourself: _____

_____

Please describe your current symptoms: _____

_____

Circle the number that corresponds to the severity of pain on a scale of 0-10. "0" means no pain and "10" is the worst pain you can imagine.

At its **worst**:	0	1	2	3	4	5	6	7	8	9	10
At its **best**:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the **character** of your pain?

Timing: ☐ Continuous ☐ Intermittent

Quality: ☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Sharp ☐ Superficial ☐ Throbbing ☐ Tingling/Numbness
☐ Other: _____

What makes your pain **worse**? _____

What makes your pain **better**? _____

How long/far can you? Sit _____ Stand _____ Walk _____

Since your injury is your pain? ☐ Better ☐ Same ☐ Worse

If your pain is unchanged, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ☐ No ☐ Yes

For office use only:

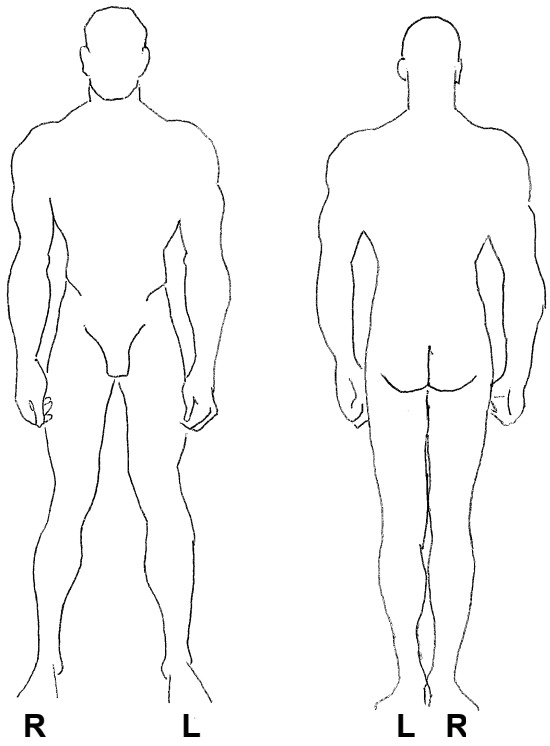
Height:	B/P:	BMI:
Weight:	Pulse:	Pain: _____ out of 10

Pain Chart

Mark the areas on your body where you feel the described sensations. Use the symbols listed. Mark areas of radiating pain or numbness as well.

Please include all affected areas.

Tingling:	= = = =
Aching:	^ ^ ^ ^
Numbness:	o o o o
Stabbing/Sharp:	/ / / /
Burning:	XX X X
Cramping:	+ + + +



Current Medications (may attach a list)

Name	Dose	# per day

Allergies (may attach a list) ☐ No known medical allergies

Substance	Reaction

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? ☐ **No** ☐ **Yes**

Patient Name: _____

PREVIOUS TREATMENT

Have you had any treatment since your injury? ☐ No ☐ Yes Have you been to the ER for this? ☐ No ☐ Yes

Have you had any of the following tests or procedures performed?

X-Rays: ☐ No ☐ Yes MRI: ☐ No ☐ Yes Epidurals/Injections: ☐ No ☐ Yes

CT Scan: ☐ No ☐ Yes EMG: ☐ No ☐ Yes Other: _____

Medical:

Dr._____ Date of 1st visit: _____ Last visit: _____

Diagnosis given: _____

Medications given: _____

Treatment provided: _____

Chiropractic: ☐ No ☐ Yes

Dr._____ Date of 1st visit: _____ Last visit: _____

Has it helped? ☐ No ☐ Yes

Physical Therapy: ☐ No ☐ Yes

Therapist_____ Date of 1st visit: _____Last visit: _____

Has it helped? ☐ No ☐ Yes Home exercise program given? ☐ No ☐ Yes

PAST MEDICAL HISTORY

☐ Anxiety	☐ Cancer (Type): _____	☐ Heart Attack	☐ Hypertension	☐ Psychiatric Illness
☐ Alcoholism	☐ Chronic Pain	☐ Heart Murmur	☐ Liver Disease	☐ Stroke
☐ Arthritis	☐ Depression	☐ Hepatitis	☐ Lung Disease	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Parkinson's	☐ Ulcers / PUD

☐ Other: _____

Have you ever had similar symptoms/injury before? ☐ No ☐ Yes

If yes, when: _____ Please briefly describe: _____

_____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐ No ☐ Yes

If yes, please list type of surgery and approximate date:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

FAMILY HISTORY: Please check box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Cancer / type: _____	☐ Heart Attack	☐ Hypertension	☐ Psychiatric Illness
☐ Alcoholism	☐ Chronic Pain	☐ Heart Murmur	☐ Liver Disease	☐ Stroke
☐ Arthritis	☐ Depression	☐ Hepatitis	☐ Lung Disease	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Parkinson's	☐ Ulcers / PUD

☐ Other: _____

SOCIAL HISTORY

Marital Status: (Check one or more) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ "Living together" ☐ Separated

Number of children:_____ Ages: _____

Do you smoke? ☐ No ☐ Yes How much? _____

Previous Smoker? ☐ No ☐ Yes I quit (when?) _____

Do you drink alcohol? ☐ No ☐ Yes How much? _____

Do you use recreational drugs? ☐ No ☐ Yes What type/how often? _____

Coffee, tea, cola beverages (cups/glasses/cans per day)? _____

Are you currently employed? ☐ No ☐ Yes If yes, type of job: _____

REVIEW OF SYSTEMS Please mark those items which you are currently experiencing:

GENERAL

☐ Fatigue	☐ Chills	☐ Weakness	☐ Weight Loss
☐ Fever	☐ Night Sweats	☐ Weight Gain	

DERMATOLOGIC

☐ Bruise easily	☐ Itching/Rash	☐ Lesions

HEAD/HEARING & VISION

☐ Blurred Vision	☐ Dizziness	☐ Headaches	☐ Tenderness
☐ Blindness	☐ Double Vision	☐ Light Sensitivity	☐ Trauma
☐ Changes / Loss	☐ Glasses	☐ Ringing in Ears	

PULMONARY

☐ Chronic Cough	☐ Shortness of Breath	☐ Wheezing

CARDIOVASCULAR

☐ Chest Pain	☐ Leg Swelling	☐ Racing Heart	☐ Shortness of Breath w/ Exertion

GASTROINTESTINAL

☐ Abdominal Pain	☐ Diarrhea	☐ Nausea
☐ Bloody Stool	☐ Heartburn	☐ Stool Color Changes
☐ Constipation	☐ Incontinence of Bowels	☐ Vomiting

GENITOURINARY

☐ Blood in Urine	☐ Irregular Menstruation	☐ Painful Burning w/ Urination	☐ Sexual Problems
☐ Diarrhea	☐ Menopause	☐ Pregnancy	
☐ Incontinence	☐ Painful Menstruation	☐ Urgency/Frequency w/ Urination	

MUSCULOSKELETAL

☐ Arthritis	☐ Joint swelling	☐ Trauma

NEUROLOGICAL

☐ Loss of Sensation	☐ Numbness and Tingling	☐ Seizures

PSYCHOLOGICAL

☐ Anxiety	☐ Depression	☐ Sadness