

**Be Fit Physical Therapy & Pilates, LTD**  
**Patient Registration Form.**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ Phone: # \_\_\_\_\_ Cell # \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Marital Status: M  S  W  D  Sex: F  M  Age: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**INSURANCE INFORMATION:**

**\*\* If your name is not printed on the front of your insurance card, you must fill out the following information:**

NAME ON INSURANCE CARD : \_\_\_\_\_

BIRTHDATE OF PERSON LISTED: \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**City, State, ZIP:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Patient Employer:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, ZIP:** \_\_\_\_\_

**Injury Information: is your condition a result of (Please Check One):**

Work Related  Injury  Auto Accident  Other: (Please Explain) \_\_\_\_\_

**When was the date of Injury/Accident/Other:** \_\_\_\_\_

\* If Worker's Compensation please supply a copy of authorization and billing information.

**Release of protected health care information via telephone to answering machine or voice mail.**

I give my consent and authorization for the Medical or Billing Staff of Be Fit Physical Therapy & Pilates, LTD., to leave protected health care information about me or for me on any answering machine or voice mail via the telephone at the number I have listed below. I understand I revoke this privilege at any time by submitting my request in writing to retrieve results of all test and procedures.

**Phone number:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Restrictions (s):** \_\_\_\_\_

Pursuant to Health insurance portability and Accountability Act of 1996, I acknowledge that I have received a copy of the Notice of Privacy Practice. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent for Treatment & Release of Information**  
**Insurance Authorization and Assignment of Benefits**

**I Authorize Be Fit Physical Therapy & Pilates, LTD to deposit checks received on my account when made out to me. I understand if the insurance company sends payment directly to me, I am responsible for returning payment over to Be Fit Physical Therapy & Pilates, LTD upon receipt of the check. Failure to do so will result in me being responsible for the total balance due on the account in full. I understand that I AM RESPONSIBLE for any and all charges, costs, and fees incurred during my evaluation and treatment program at Be Fit Physical Therapy & Pilates, LTD., not covered by my insurance carrier (S). In the case of no insurance coverage, I am responsible for payment in full.** If I am unable to pay the balance until paid in full, It is my responsibility to make financial arrangements and make regular payments on my account balance until paid in full. Further, I understand that all delinquent accounts are turned over for collection to a third party agency if no payment is received for 75 days. This agency does report to all credit bureaus for recording on personal credit history. If I fail to pay for these services, I agree to pay the collection agency fees, attorney fees, and court costs incurred in collecting the dept. I consent to the above billing procedures as confirmed by my signature below.

I, or my (child) has a condition, which a licensed physician has prescribed physical therapy as part of my treatment plan. I request and consent to Be Fit Physical Therapy & Pilates, LTD and its physical therapist, assistants, and professional staff, to perform therapeutic procedures that may be necessary for my rehabilitative treatment as necessary and desirable in the exercise of professional judgment. It is not possible to make guarantees concerning the results of this or any treatment. I acknowledge that no such guarantees have been made to me. I also authorize Be Fit Physical Therapy & Pilates, LTD to obtain and release any medical information, verbal or written, necessary to provide appropriate patient care. I understand that all information exchanged is maintained under the Be Fit Physical Therapy & Pilates, LTD confidentially policy.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Be Fit Physical Therapy & Pilates, LTD**  
**MEDICAL INFORMATION**

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, we will be happy to assist you. Thank you.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB \_\_\_\_\_

Occupation: \_\_\_\_\_ Leisure Activities: \_\_\_\_\_

Please circle any of the following medical professional you are currently seeing:

Medical Doctor   Osteopath   Physician Assistant   Physical Therapist   Chiropractor   Dentist   Nurse Practitioner

If you have been seen by any of the above during the last three months, please describe for what reason ( illness, medical condition, physical examination, ect.)

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Please circle any of the following condition that you have EVER been diagnosed with and Describe below

|                            |                |                    |           |            |        |
|----------------------------|----------------|--------------------|-----------|------------|--------|
| High/Low blood pressure    | Heart Problems | Thyroid problems   | Diabetes  | Emphysema  | Asthma |
| Chemical Dependency        | Alcoholism     | Multiple sclerosis | Hepatitis | Depression | Stroke |
| Rheumatoid arthritis       | Tuberculosis   | Kidney disease     | Anemia    | Epilepsy   | AIDS   |
| Other Arthritic Conditions | Cancer         | Other              |           |            |        |

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Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date: \_\_\_\_\_ Surgery/ Hospitalization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date: \_\_\_\_\_ Injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please circle the condition below that any in your immediate family (parents, brothers, sisters have ever been treated for?)**

|                         |                |                |          |                     |
|-------------------------|----------------|----------------|----------|---------------------|
| High/Low blood pressure | Heart disease  | Kidney disease | Diabetes | Chemical Dependency |
| Alcoholism              | Kidney Disease | Tuberculosis   | Epilepsy | Mental Illness      |
| Arthritis               | Headaches      | Stroke         | Anemia   | Cancer              |

**Please circle the following OVER-THE-Counter medication you have taken in the last week.**

|         |          |           |                |               |
|---------|----------|-----------|----------------|---------------|
| Advil   | Motrin   | Ibuprofen | Tylenol        | Decongestants |
| Vitamin | Antacids | Laxatives | Antihistamines | Others: _____ |

**Please list any PRESCRIPTION medication you are currently taking: (pills, injections, and/or skin patches)**

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**Please list any Drug, Food, Seasonal, or Product ALLERGIES:**

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**Is there anything else you would like for us to know?**

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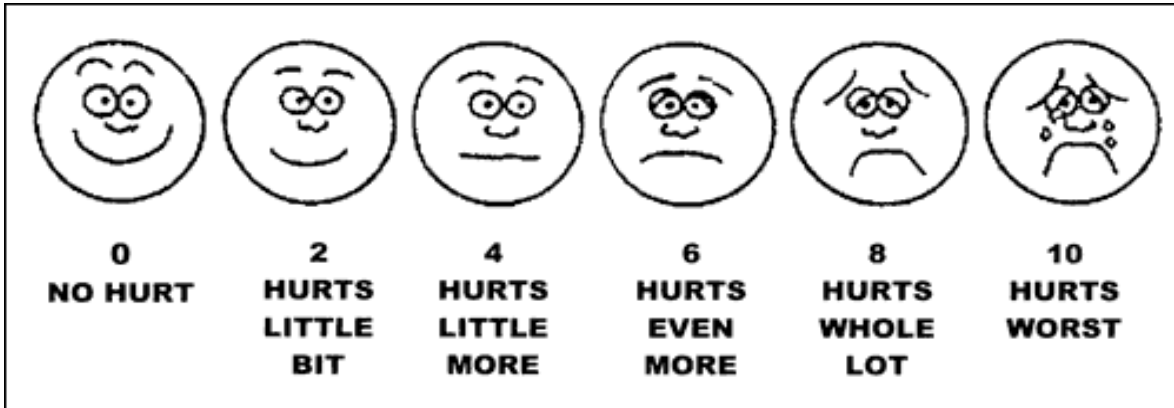
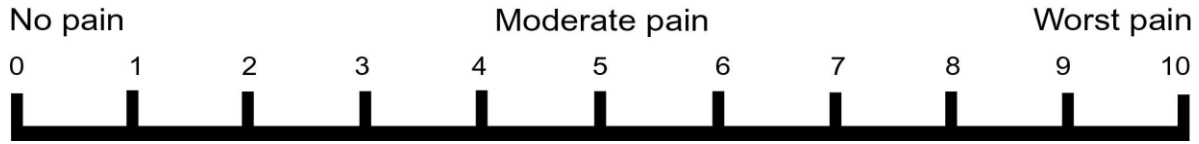
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**Please circle either the correct answer to the question below:**

**Have you currently experienced:**

|     |    |                       |
|-----|----|-----------------------|
| Yes | No | Weight loss/ Gain     |
| Yes | No | Nausea/ Vomiting      |
| Yes | No | Fatigue               |
| Yes | No | Weakness              |
| Yes | No | Fever/ Chills/ Sweats |
| Yes | No | Numbness or Tingling  |

Do you have any pain? Yes  No   
 If yes, please mark the areas on the drawings below.  
 On the following scale of 0 – 10, how would you rate your pain?



**Pain is:**  constant  intermittent \_\_\_\_\_

**Do you have other symptoms?**

- swelling  stiffness  weakness  tenderness  tightness
- limited motion  numbness  tingling sensation
- others: \_\_\_\_\_

**Due to your condition do you have difficulty:**

- walking  balancing
- sleeping  getting up from bed/chair
- personal care activities (dressing, washing, etc.)
- performing work duties
- performing light domestic duties
- performing heavy domestic duties
- performing your recreation/ sport activities
- commuting/ traveling

What are your goals? \_\_\_\_\_

How did you hear about Be Fit Physical Therapy? \_\_\_\_\_

\_\_\_\_\_  
**Patient/ Guardian Signature**

\_\_\_\_\_  
**Date**