

Pacific Balance and Rehabilitation Clinic

Patient Registration

PLEASE PRINT

Personal Information

Patient Name _____ Mr. Ms. Miss Mrs.
Last First Middle Today's Date: _____
Address _____ Home Phone (____) _____ - _____
City State Zip Work Phone (____) _____ - _____
Birth Date _____ Mobile Phone (____) _____ - _____
Soc. Sec. # _____ Email _____
Marital Status ___ Single ___ Married ___ Other
We prefer billing by email. Please indicate if interested: ___ Yes ___ No
Emergency Contact (Nearest friend or relative not living with you):
Name: _____ Phone: _____ Relationship: _____
We also accept electronic payments.

Nature of Injury/Symptom

Whom may we thank for referring you to this office? _____
Primary Care Physician _____
Date of Injury / Symptom _____ Body Part Involved _____ *right or left*
Cause of Injury _____

Billing Information

If Other than Patient, Insurance Subscriber Information:

Patient's Occupation _____
Patient's Employer _____
Employer's Address _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Phone _____

Subscriber Name _____
Address _____
Home Phone _____
Work Phone _____
Subscriber's Birth Date _____
Patient Relationship to Insured _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

Please complete the following as it applies to you:

Did your injury happen at work? ___ Yes ___ No

Date of Accident _____ Employer at time of Injury _____
Insurance Company _____ Claim Number _____
Insurance Address _____ Insurance Phone _____

Were you involved in a motor vehicle accident? ___ Yes ___ No

Date of Accident _____ Insurance Company Name _____
Claim Number _____ Insurance Address _____
Ins Co. Phone _____ Attorney Phone _____
Attorney Name _____ Are they currently paying on your claim? _____

PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE ABOVE QUESTIONS

Assignment and Release: I hereby assign to Pacific Balance and Rehabilitation Clinic, PLLC ("PBRC") any and all benefits from any insurer, third party or other protection maintained for my benefit, and authorize and direct that such benefits be paid directly to PBRC for services provided by PBRC. I also authorize the release of any of my health information to any person or entity that is or may be responsible for payment for services rendered by PBRC, including without limitation, insurers and third party payers. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 30 days. If I do not pay the balance in full within 30 days of the monthly billing date a finance charge will be added to the account of 1% per month which is an annual percentage rate of 12%. The above information is complete and accurate to the best of my knowledge and I understand and accept the information above.

Signature of Patient
(or patient's authorized representative)

Relationship/ Status if signed by anyone other than the patient
(e.g. parent, legal guardian, personal representative)

Date

Patient: _____ Age: _____

Diagnosis or Problem Area: _____

Please complete this questionnaire so that we are able to provide you the best possible care. Check any problems below that you have now and/or have had trouble with in the past.

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Bleeding/Bruising Easily |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Numbness to Hands and Feet | <input type="checkbox"/> Skin Rash/Disease |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Severe Night Pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Difficulty with Balance | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Frequent Falls | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Surgery Please list: |
| <input type="checkbox"/> Other Orthopedic Injuries | _____ |

Do you smoke? _____

Do you exercise? _____ If so, how often? _____

Do you get short of breath with exertion (up/down stairs)? _____

Women, is there any chance of pregnancy? _____

Please list any medications you are taking: _____

On a scale of 1-10 with 1 being the least or no pain and 10 being extreme pain, what would you rate your injury/problem area when it acts up? _____

List some activities that seem to aggravate your injury/problem area _____

List some activities that seem to relieve your injury/problem area _____

Do you have any other special problems/concerns we should know about?

Patient Signature

Parent / Guardian Signature

Date

I have been presented with a copy of Pacific Balance and Rehabilitation Clinic's **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

Consent to Leave Messages

We at Pacific Balance and Rehab are working hard to ensure that confidentiality regarding your Protected Health Information and treatment is maintained at all times. Due to confidentiality concerns and to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we require your signature allowing us to leave a message about your upcoming office visit, account information, or any other information you may want us to convey to you via telephone or electronic messaging.

Please complete and sign this form, indicating your preference.

I, _____, give Pacific Balance and Rehab permission to:

- Leave a message regarding my upcoming office visit, account information, or other pertinent information on my answering machine.

YES / NO

- Leave a message with someone who answers the phone at my residence.

YES / NO

- Leave a message at my place of employment.

YES / NO

Signed: _____ **Date:** _____