Great Northern Rehab

NEW PATIENT REGISTRATION FORM

Patient's Name_____
Last First Middle Initial

Street Address_____
City State Zip

Mailing Address_____
City State Zip

Home Phone_____ Work Phone_____

Cell Phone _____ Driver's License Number:_____

Date of Birth_____ Social Security #_____

Sex ☐ Male ☐ Female **Date of Injury**_____

Patient's Status ☐ Single ☐ Married ☐ Other

EMAIL ADDRESS_____

Are you currently receiving ANY Home Health Services ☐ Yes ☐ No

Employer / Company at time of injury:

Name_____Phone#:_____

Street Address_____
City State Zip

HOW DID YOU HEAR ABOUT GREAT NORTHERN REHAB? ☐ Doctor ☐ Friend/Relative ☐ Advertisement ☐ Phone Book ☐ Other_____

WHO MAY WE CONTACT IN CASE OF EMERGENCY?

Name_____ Phone Number_____
Relationship_____

INSURANCE INFORMATION (check one please) ☐ MC ☐ Tricare/Champus ☐ Auto ☐ BC/BS

Subscriber's Name_____ ☐ WC ☐ Medicaid ☐ Commercial
SS #_____ DOB_____
Insurance Name_____
Street Address_____
City State Zip
Subscriber's Number_____ Group Number_____
Employer Name_____
Street Address_____
City State Zip
Secondary Insurance_____

AUTHORIZATION FOR TREATMENT

I authorize Great Northern Rehab, its employees and agents as well as any and all independent contractors engaged by Great Northern Rehab to perform the services on my behalf as they may deem necessary.

Signature_____ Date_____

Great Northern Rehab

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION
AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We feel strongly that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

PLEASE READ AND INTIAL THE FOLLOWING:

_____ I authorize this office to release or receive any information necessary to expedite insurance claims

_____ I hereby authorize this office to bill my insurance company directly for their services

_____ I authorize payment directly to this provider of my insurance benefits otherwise payable to me

_____ In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable

_____ I hereby authorize Great Northern Rehab and/or occupational therapist(s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize Great Northern Rehab to perform any service (evaluation, treatment procedures, and testing) necessary for my rehabilitation

_____ Great Northern Rehab is granted permission to release to the insurance carrier, employer, attorney, their representatives, or referring physician, any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.

_____ **HIPAA** – I have received the Practice's "Notice of Privacy Practices" and understand that my protected health information may be used by the Practice as described in the notice.

_____ **I** authorize **GNR** to discuss my healthcare information, billing/payment for services

to person: Name: Relationship: Date:

I understand that I am directly and completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee.

A Photostat copy of these authorizations and agreements shall be as valid as the original.

_____ _____ _____

Patient or Guardian (print) Patient or Guardian (signature) Date

Great Northern Rehab

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 leave it blank and your therapist will assist you. ***Thank you!***

Name:_____Leisure Activities:_____

Age:_____Occupation:_____

ALLERGIES: List any medication(s) you are allergic to:_____

Are you latex sensitive? Yes No List any other allergies we should know about:_____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Do you have a pacemaker? Yes No

Please check (√) any of the following whose care you're under

___Medical doctor (MD) ___Psychiatrist/Psychologist

Other_____

___Osteopath ___Physical Therapist

_____

___Dentist ___Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition,
physical, etc…)

_____

_____

Have you **EVER** been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical Dependency (i.e. alcoholism)
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Other Arthritic Conditions
YES NO Depression
YES NO Infections (positive blood test for Hepatitis, HIV, AIDS)
YES NO Tuberculosis
YES NO Stroke, TIA
YES NO Kidney Disease
YES NO Anemia
YES NO Epilepsy
YES NO Other

For Office Use

Great Northern Rehab

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

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 REASON FOR SURGERY/HOSPITALIZATION

1._____ 2._____

3._____ 4._____

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

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Kidney disease
YES NO Alcoholism (chemical dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Other_____

For Office Use

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

1._____ 2._____

3._____

4._____ 5._____

6._____

Great Northern Rehab

How much caffeinated coffee or caffeine containing beverages do you drink per day?
_____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting?
_____

Have you recently noted:

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

For Office Use

_____ _____
Signature **Date:**

_____ _____
Therapist Signature **Date:**