BURBANK THERAPY CENTER • PATIENT REGISTRATION FORM

Welcome to our facility. To serve you properly, we will need the following information. **(PLEASE PRINT)**

Patient's Name	**Sex** M ☐ F ☐	**Birth Date** **Age** _____	**Marital Status** Single ☐ Married ☐ Widowed ☐ Divorced ☐
Residence address **City**	**State** **Zip**	**Cell Phone**	**Patient's Social Security#**
Person responsible for this insurance **Self** ☐ **Spouse** ☐		**Responsible Party's Birth Date**	
Person to contact in case of emergency: **Phone number**		**Relationship to patient**	
ARE YOU CURRENTLY EMPLOYED Y ☐ N ☐ If no proceed to insurance	**Occupation**		**How long at current employer?**
Name of Employer **Address**			**Business Phone Number**
E-mail address:		**Text Message reminder opt-out:** ☐	

MEDICARE and INSURANCE INFORMATION (Skip if you bring an insurance card)

Medicare YES ☐ NO ☐	**Medicare Number:**		**Effective Date**
Primary Insurance Number **Address**		**Policy#** **Group#**	**Effective Date**
Secondary Insurance Number **Address**		**Policy#** **Group#**	**Effective Date**
Subscriber's Name **Address**			**Phone Number**
Subscriber's Date of Birth: **Subscriber's SSN:**		**Relationship to patient**	
☐ **Personal Injury Accident** **Date of Accident** ☐ **Worker's Compensation** **Claim number**		**Carrier's name and address**	**Carrier's phone number** **Authorization number**
Attorney's Name **Phone number** **Address**			

Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure. I have received a copy of my Patients' Rights and Responsibilities.

_____ _____

Patient or Representative Signature Date

BURBANK THERAPY CENTER • PATIENT CONSENT & RIGHTS/RESPONSIBILITIES

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make this notice available to you. When you sign and date this form you are agreeing that you were given a copy of this notice.

The notice states that we may use and disclose protected health information about you for your treatment, payment, and health care operations. In your notice, there is a complete list of examples of how we may disclose your personal health information without specific authorization from you.

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No	
Leave a message with someone at home? With whom:_____	Yes	No	
Leave a message at your place of work?	Yes	No	N/A
Perform Telehealth services as needed?	Yes	No	

Other than your doctor, please list full name & relationship of anyone with whom we may discuss your condition:

_____

Summary Of Patient's Rights And Responsibilities

We are committed to serving with compassion, skill and respect. As our patient, you have rights & responsibilities.

You have the *RIGHT:*

- To be treated with dignity and respect
- To know the names and professional status of people serving you
- To privacy & the confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects and problems of all forms of treatment
- To participate in choosing a form of treatment
- To receive education and counseling
- To consent to or refuse any care or treatment
- To select and/or change your healthcare provider
- To review your medical records
- To information about services and any related costs

You also have the *RESPONSIBILITY:*

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and medical instructions
- To report any significant changes in symptoms or failure to improve
- To respect clinic policies & keep appointments (or cancel in advance)
- To seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

Patient Name:_____

_____ _____

Patient or Representative Signature Date

BURBANK THERAPY CENTER • MEDICAL HISTORY FORM

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Are you currently having Physical Therapy anywhere? ☐ Yes ☐ No

Are you currently getting Home Health Services (does a nurse come to your house?) ☐ Yes ☐ No

Do you have pain or weakness in your:
____ Neck ___ Back ___ Upper Extremities (shoulders, wrists) ___ Lower Extremities (hips, legs)

Current Living Environment:

Do you live: ☐ Alone ☐ With Spouse ☐ With Family Member ☐ With Friend;

In a: ☐ single level home; ☐ double or-tri-level home; ☐ Apartment ☐ Assisted Living;

Do you have stairs in your home; ☐ yes (if yes, how many?) _____ ☐ No

Who does the cooking, cleaning, laundry and shopping in your home: _____

Employment: ___ full-time ____ part-time _____ retired ____disabled

Occupation:_____

Smoking History: ☐ Yes ☐ No (If yes, when did you quit?_____)

Contraindications/Precautions: _____

Have you been hospitalized in the past year? ☐ No ☐ Yes
(If yes, please describe including approx. dates, location, and reason for hospitalization)

_____

_____

_____

Have you ever had COVID-19? YES NO (circle one)

Have you been vaccinated?:_____When:_____

List your current medications (including non-prescription medication):

_____

_____

_____

Name: _____ DOB:_____

CURRENT MEDICAL HISTORY (*check all that apply*):

Pulmonary/Lungs

- □ Obstructive sleep apnea
- □ Frequent bronchitis
- □ Emphysema
- □ Frequent pneumonia
- □ Asthma
- □ Pulmonary embolism
- □ Tuberculosis
- □ ILD/Pulmonary Fibrosis
- □ Bronchiectasis
- □ Pulmonary Hypertension
- □ Pulmonary Edema
- □ Sarcoidosis
- □ COPD
- □ COVID
  (if yes, please indicate the date: _____)

Cardiovascular

- □ History of angina or heart attack
- □ Hypertension
- □ History of arrythmia
- □ History of poor circulation
- □ Rheumatic fever
- □ Congestive Heart Failure
- □ Heart valve disease
- □ Blood clots
- □ Pacemaker/ Defibrillator
- □ High Cholesterol

Muscle/Joint/Bone

- □ Osteoarthritis
- □ Osteoporosis
- □ Gout
- □ Rheumatoid arthritis
- □ Joint Replacement (where/when: _____)
- □ Fractured/broken bones (where:_____)
- □ Fibromyalgia
- □ Osteopenia
- □ Neck/Back/Shoulder pain
- □ Hip/Knee/Ankle pain (right, left or bilateral)

Neurologic

- □ History of stroke
- □ Seizures/Epilepsy
- □ TIA
- □ Dementia
- □ Vertigo
- □ Depression/Anxiety
- □ Peripheral Nerve Disease
- □ Insomnia
- □ Migraine
- □ Memory Loss
- □ Panic Attacks
- □ Neuropathy

General

- □ Weight gain/loss of 10+lbs. during last 6 months
- □ Cancer/Tumor: specify_____
- □ Possible pregnancy (women)

Eyes, Ears, Nose, Throat

- □ Blurred vision/glasses/contacts
- □ History of glaucoma or cataracts
- □ Loss of hearing
- □ Ringing in ears
- □ Sinus problems
- □ Allergies
- □ Frequent ear infections

Genitourinary

- □ Frequent or painful urination
- □ Bladder infections
- □ HIV infection

Skin/Breast

- □ Itching/Psoriasis
- □ Easy bruising
- □ Change in moles
- □ Abnormal mammogram
- □ Rashes
- □ Hives

Lymphatic/Hematologic/Metabolic

- □ Diabetes Mellitus
- □ Hyper/Hypo-thyroid
- □ Anemia
- □ Blood transfusion (if yes, when:_____)

Gastrointestinal

- □ Poor appetite
- □ Abdominal pain
- □ Kidney failure
- □ Trouble swallowing
- □ Diarrhea/Constipation
- □ Hemorrhoids
- □ Stomach Ulcers
- □ Nausea or vomiting
- □ Rectal bleeding or blood in stools
- □ Liver failure
- □ Diverticulitis
- □ Crohn's disease
- □ Hepatitis
- □ Colon polyps
- □ Prostate Disease
- □ Pancreatitis

Patient Name: _____

DOB: _____

BURBANK THERAPY CENTER • GOALS AND PSYCHOSOCIAL SERVICES

List goals or activities you would like to be able to do after completing therapy: _____

_____

_____

PSYCHOSOCIAL SERVICES:

Burbank Therapy Center offers psychosocial services. Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

- □ Yes If YES, please write a short reason for evaluation:
  _____
- □ No If NO, ***please sign declination below***:

I am aware of an LCSW on staff and psychosocial services at Burbank. At this point, I do not require a psychosocial evaluation.

_____

Patient or Representative Signature (***if declining LCSW Services***)

CERTIFICATION:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERED TO MY SATISFACTION. I WILL NOT HOLD THE PROGRAM OR ANY OF ITS STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____

Patient Name DOB

_____ _____

Patient or Representative Signature Date

FOR OFFICE USE ONLY:

Explanation offered to patient/family/caregiver regarding our services, their purpose and our expectations:
☐Yes ☐ No; if no, were corrective actions taken? ☐Yes ☐ No