37624 SE Fury St. Ste C201
Snoqualmie, WA 98065
ph: 425.292.0223
fax: 425.292.9225

PATIENT REGISTRATION INFORMATION

Name:____ Social Security #: ______-_____-______
Last First Middle
Address: ____ _________________ _________ ___________
Street City State Zip
Home Phone: (____) ______-_______ Cell Phone: (____) _____-_______ Work Phone: (____) _____-________
Edge Physical Therapy & Rehab is authorized to leave a detailed message on: ( ) Cell ( ) Home ( ) Work
Date of birth: _______________ Gender: ____ Marital Status: ____ Email ________________________________
Employer: ______________________________ Occupation: ____

How did you find Edge: ____ Doctor Referral ____ Saw the sign ____ Previous Patient ____Website ____ Internet
___ Recommended to me by a friend or family member* ___ Other:____
*If a friend or family member referred you to us, we would like to personally thank them. Please give us their contact information. Thank you.
Name: ______________________________________ Address/Email: ____________________________

Referring Physician: ___________________________ **Phone Number:** _______________________________
In Case of EMERGENCY:
Name: _______________________________ Home (_____) _____-______ Cell (_____)_____-________
Relationship: ________________________________

<u>If someone other than the patient is the SUBSCRIBER and/or RESPONSIBLE for payment, complete the following (circle all that apply)</u>:
Name: ________________________ Address: ____
Relationship to patient: __________________Social Security #: ____-____-_____ Birth date _______________
Home Phone (____) ____-_____ Cell Phone (____) ____-______ Work Phone (____) ____-______

Insurance: (check one) **Auto**___ Name/Claim#: _________________ **Worker's Comp(L&I)**___ Claim#:___________
Private Healthcare____ **Primary:** ___________________________ **Secondary:**_____________________________

CONSENT TO CARE: I consent to the plan of care proposed by the providers in this clinic. I understand that, I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care. This consent is intended as a waiver of liability for such treatment except acts of negligence. I understand that Edge PT & Rehab participates in the training of health care providers, and I will be told when trainees take part in my care. _______

NOTIFICATION OF RELEASE FOR PAYMENT: I understand that Edge PT & Rehab will disclose any diagnose and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substances abuse, or mental health conditions. _______

FINANCIAL AGREEMENT: I understand co-payments are due at the time of service. I assign payment from my insurance directly to Edge PT & Rehab. I understand I am financially responsible to Edge PT & Rehab for the charges not paid by insurance and that those charges are due within 30 days of invoice. We will bill your open, approved worker's compensation claim. I am aware that in the event my claim is denied, I am financially responsible for all charges**. If you need to cancel or change an appointment we require 24 hours prior notification to avoid a cancellation fee of $40.00**. If you are an industrial injury patient, your claims manager will be notified about the missed visits, and you will be discharged from care. _______

RECEIPT OF HEALTH INFORMATION PRACTICES: I have received a copy of Edge PT & Rehab's Notice of Health Information Practices which provides information about how my health information may be used and disclosed. _______

I have read the above and understand its contents:

Responsible Party Signature ____ **Date**: ____________

<u>Non-Discrimination:</u> Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability or age. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 protect all clients who come to our clinic for services.

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Please check any of the following health conditions that you have currently or have experienced in the past:

Diabetes	___	Unexplained Weight Loss	___
Cancer	___	Bowel and/or Bladder Changes	___
Heart Disease	___	Decreased Coordination	___
High Blood Pressure	___	Night Sweats and/or fevers	___
Low Blood Pressure	___	Appetite Changes	___
Angina/Chest Pain	___	Nausea and/or vomiting	___
Strokes or TIA	___	Shortness of Breath	___
Pacemaker	___	Difficulty swallowing	___
Kidney disease	___	Difficulty breathing	___
Liver disease	___	Depression	___
Seizures	___	Fainting	___
Lung disease	___	Numbness and/or tingling	___
Asthma	___	Anxiety and/or stress	___
Ulcers	___		
Vision problems	___		
Gastrointestinal Issues	___		
Hearing Loss	___		
Thyroid Problems	___		
Communicable Disease	___	Please list: ______________________	
HIV/AIDS	___		
Osteoporosis	___		
Osteoarthritis	___		
Rheumatoid arthritis	___		
Fractures	___		
Joint replacement	___		
Disc Herniation	___		
Migraines/Headaches	___		
Metal Implants	___		
Currently Pregnant	___	If Yes, Due date: __________________	
Other condition (not mentioned above): ______			

List any allergies:

List any surgeries or injuries:

List all current medications:

Print Name: ____

Signature: ____ **Date:** ______________________

info@edgeptandrehab.com | www.edgeptandrehab.com

EDGE
PHYSICAL THERAPY
& REHABILITATION

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Present Medical History:

Please list your area of injury or condition you wish to have us address today:
____

Date of injury or start of condition:____

Briefly describe the cause:____

Please rate your current pain level 0 1 2 3 4 5 6 7 8 9 10 (0= no pain, 10= worst imaginable)
Worst pain level (in last week): _______ Best pain level (in the last week): ______

Please mark the location of your pain or symptoms on the body map

What aggravates or makes your symptoms worse?
____

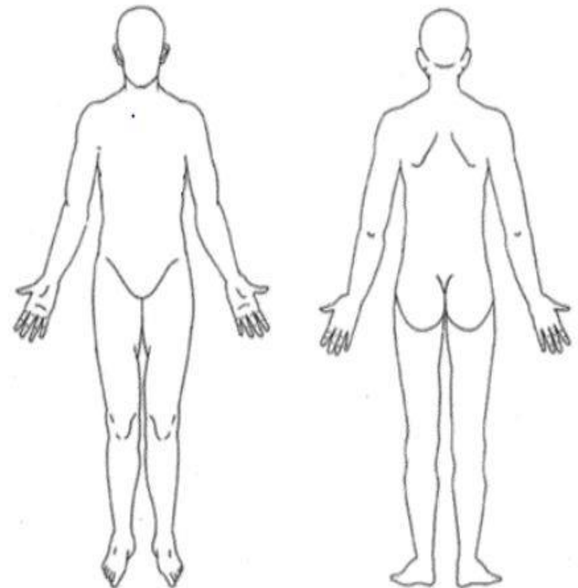
What alleviates or makes your symptoms better?
____

Have you had any treatment already for your concerns?
If yes, please list:
____

Did it help? Yes ____ No ____

Have you had similar complaints in the past? If yes,
please explain: _____________________________

Please list any tasks or activities you cannot participate
in now that you previously could do:
____



Please list the goals you have from physical therapy and what specifically you would like to achieve:
____

Is there anything else you wish us to know about you before we begin:
____

When do you see your referring provider (ex: physician, chiropractor) next?______________________

Please sign and date:

____

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