Coppersmith
Orthopedic & Sports Physical Therapy

5025 25th Ave NE, # 201, Seattle, WA 98105 206-524-6702

Patient Registration -1

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Address 2 _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ SSN _____ Gender _____ Marital Status _____

Emergency Contact:

Name _____ Relationship _____ Phone _____

Employer:

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Problem:

Description _____

Date of Injury _____ Last Physician Visit _____

Referred By _____ Primary Care Physician _____

Motor Vehicle Accident? _____ Date occurred _____

Primary Insurance: *Subscriber:*

Insurance _____ Name _____

ID # _____ Relationship _____

Group # _____ Date of Birth _____

Secondary Insurance: *Subscriber:*

Insurance _____ Name _____

ID # _____ Relationship _____

Group # _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 206-524-6702, requesting one at this office, or on the web at www.coppersmithpt.com.

Signature _____ Date _____

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature _____ Relationship _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE COPPERSMITH ORTHO & SPORTS PHYSICAL THERAPY TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY OR MY DEPENDENT'S EXAMINATION OR TREATMENT ONLY TO THE AUTHORIZED INSURANCE CARRIER, LEGAL COUNSEL, OR REQUESTING PHYSICIAN.

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS

I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO COPPERSMITH ORTHO & SPORTS PHYSICAL THERAPY AND/OR THE PHYSICAL THERAPISTS OF COSPT FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS COVERED UNDER MY INSURANCE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY AND ALL MEDICAL BILLS INCURRED.

Signature _____ Date _____

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Patient Registration - 2

To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested on this form. If you do not understand a question, please leave it blank and your therapist will assist you. Thank you!

Allergies: Please list any medications you are allergic to: _____

Please list any other allergies: _____

Are you latex sensitive? ☐ Yes ☐ No

Please check any of the following whose care you are under:

☐ Physician (MD, DO) ☐ Podiatrist (DPM) ☐ Psychiatrist/Psychologist

☐ Physical Therapist ☐ Chiropractor (DC) ☐ Other: _____

If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine, etc) _____

_____

Do you have an Advanced Directive? ☐ Yes ☐ No _____

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

☐ Yes ☐ No Cancer
☐ Yes ☐ No Heart Problems
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Circulation Problems
☐ Yes ☐ No Asthma
☐ Yes ☐ No Emphysema/Bronchitis
☐ Yes ☐ No Chemical Dependency
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Rheumatoid Condition
☐ Yes ☐ No Other Arthritic Condition
☐ Yes ☐ No Depression
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Stroke
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Anemia
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Currently pregnant

Have you recently noticed?

☐ Yes ☐ No Weight loss/gain
☐ Yes ☐ No Nausea/Vomiting
☐ Yes ☐ No Dizziness/Lightheadedness
☐ Yes ☐ No Numbness or tingling
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Weakness
☐ Yes ☐ No Fever/Chills/Sweats

Please place an **"X"** on each line to indicate the intensity of your pain or other symptoms:

Current Pain: Mark to indicate your pain level **at the present time**.

(No Pain) (Worst Pain Ever)

Least Pain: Mark to indicate the least amount of pain you have had i**n the last week.**

(No Pain) (Worst Pain Ever)

Worst Pain: Mark to indicate the worst amount of pain you have had i**n the last week.**

(No Pain) (Worst Pain Ever)

Please list any prescription and/or over the counter medications you are currently taking:

Please describe any surgeries or significant injuries for which you have treated:

Date: Date:

Date: Date:

Date: Date:

Briefly state your personal goals for your Physical Therapy treatment: