Stellar Physical & Occupational Therapy & Acupuncture, PLLC

87-09 Justice Avenue Elmhurst, NY 11373 *2 Hope Drive Plainview, NY 11803*

Tel: (718) 699-5070 Fax :(718) 699-5071 *Tel: (516) 822-2118 Fax: (516) 234-7762*

PATIENT REGISTRATION FORM 登记表

Name (Last, First):	**Date of Birth**: ____ /____ / _____	**Gender**: Male ___ Female ___

Address:	**City/State/Zip Code:**

Home Phone:	**Cell/Work**:	**Email:**

Marital Status: Single __ Divorce __ Married __ Other __	Occupation_____ Employer: _____ Phone: _____	**SS No.** _____ **Driver's License No.**: _____

Emergency Contact: _____ Relation: _____ **Phone No.**: _____	Primary Care Physician: _____ Tel:_____ Referral Physician: _____ Tel: _____

Primary Insurance	Subscriber's Name	Date of Birth ___ / ___ / _____
Policy No.	Group No.	Relationship to insured: □ Self □ Spouse □ Child □ Other
Secondary Insurance:	Policy No.	Phone:

Assignment of Benefits and authorization to release medical information

I certify that all information above is true and correct. I authorize and direct Stellar Physical & Occupational Therapy & Acupuncture, PLLC, having treated me to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representative therefor to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Stellar Physical & Occupational Therapy & Acupuncture, PLLC sufficient monies and/or benefits to which i may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

(Medicare) I certify that the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information given by me to release to the SS Administration and HCFA or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable of speciality services to specialists furnishing the services or authorize such specialists to submit a claim to Medicare for payment to me.

Patient/Guardian
Signature: _____ Date: _____

Patient HIPPA agreement

With my permission, Stellar Physical & Occupational Therapy & Acupuncture, PLLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

With my permission, the office or representative of Stellar Physical & Occupational Therapy & Acupuncture, PLLC may call my home or other designated locations and leave a message on voicemail or with a person in reference to any item(s) that may assist the practice in carrying out necessary healthcare operations, such as appointments, reminders, insurance matters and any information pertaining to billing and collections or my medical care, including laboratory results and prescriptions among other health care or administrative matters.

With my permission, the office or representative of Stellar Physical & Occupational Therapy & Acupuncture, PLLC may mail to my home or other designated locations any items that may assist the practice in carrying out healthcare operations related to me, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. Stellar Physical & Occupational Therapy & Acupuncture, PLLC is not to be held responsible for any damages that may be caused by an unauthorized person attaining such information without my consent. I have the right to request that Stellar Physical & Occupational Therapy & Acupuncture, PLLC restrict how it uses or discloses my personal health information to carry out healthcare operations. However, Stellar Physical & Occupational Therapy & Acupuncture, PLLC or its representative reserve the right to decline my request, though if it does agree it is bound by this agreement.

By signing this form, I am allowing Stellar Physical & Occupational Therapy & Acupuncture, PLLC to use and disclose my personal health information for my treatment, payment and other reasonable healthcare operations.

I may revoke my consent in writing for further disclosures except to the extent of any and all information that Stellar Physical & Occupational Therapy & Acupuncture, PLLC has already disclosed in reliance upon my prior consent.

Patient/Guardian
Signature: _____ Date: _____

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Name (Last, First): _____ **Gender: Male / Female**
Date of Birth: ___ /___ / _____ **Exam Date:** _____

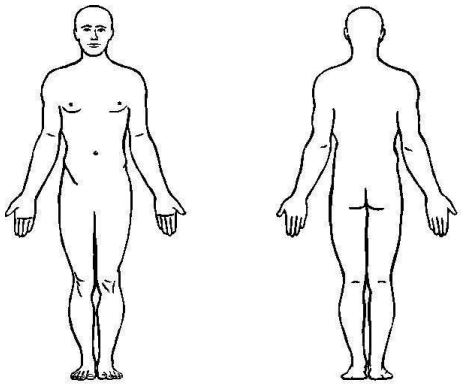
Medical Condition

Describe Your Current Problem, How It Begin and How long

_____
_____
_____

Onset Date/Surgery Date _____

Indicate 'X' below where you have pain or other symptoms



Is your condition due to An accident__ Work __ Other _____

How often are your symptoms present?

_ **Constantly** (76-100 % of the day) _ **Occasionally** (26-50 % of the day)
_ **Frequently** (51-75 % of the day) _ **Intermittently** (0-25 % of the day)

Describe the nature of your pain:

_ Sharp _ Dull Ache _ Numb _ Tingling _ Shooting
_ Burning _ Localized _ Radiating

How is your condition changing?

_ Getting Better _ Not Changing
_ Getting Worse

Current complain (how you feel today): circle it

[_____]
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

[_____]
No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

In general would you say your overall health right now is:

_ Excellent _ Very Good _ Good _ Fair _ Poor

Have you had X-Rays, MRI, CT Scan for your area(s) of complaint: _ Yes _ No
Date(s) take _____ What area(s) were taken? _____

Please check all of the following that apply to you:

_ Asthma
_ Anemia
_ Cardiac Condition
_ Pacemaker
_ Stroke (Date) _____
_ High Blood Pressure
_ High Cholesterol
_ Surgeries _____

_ Diabetes _ Type 1 _Type 2
_ Hepatitis ____
_ Osteoporosis _ Arthritis
_ Kidney Disease
_ Urinary Problems
_ Cancer/Tumor_____
_ Recent Fever

_ Numbness (Location) _____
_ Dizziness/Fainting
_ Pain at Night
_ Pain Unrelieved by Position or Rest
_ Currently Pregnant, # weeks _____
_ Abnormal Weight _ Gain _ Loss
_ HIV/AIDs
_ Other _____

Smoking __ (__ cigarettes __ packs per day) Alcohol __ (_ Social Drinker_ Heavy Drinker) Weight: _____ **Height:** _____

Current Medications:_____
_____

Who have you seen for your condition before today?

_ No One _ Medical Doctor _ Massage Therapist _ Other_____
_ Chiropractor _ Physical Therapist _ Acupuncturist

Major Hospitalization: _____ Drug Allergies: _____

Patient Signature: _____**Today's Date:** _____**INS:**_____

REFERRAL SOURCE: □ Doctor □ Friend □ Other (please specify): _____