PATIENT REGISTRATION FORM

Welcome to our center. In order 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**	**Home Phone** **Email Address**	**Patient's Social Security#**
Person financially responsible for this account **Self** ☐ **Spouse** ☐		**Responsible Party's Birth Date**	**Responsible Party's Social Security#**
Person to contact in case of emergency:	**Phone number**	**Relationship to patient**	
ARE YOU CURRENTLY EMPLOYEED Y ☐ N ☐ If no proceed to next section	**Occupation**		**How long at the current employer?**
Name of Employer Address			**Business Phone Number**
Referred by: (include address and phone number)			

MEDICARE and INSURANCE INFORMATION

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 Social Security Number:**		**Relationship to patient**	
☐ **Personal Injury Accident** ☐ **Worker's Compensation**	**Date of Accident** **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 and this facility's Grievance Procedure.

_____ _____

Patient's signature Date

_____ _____

Patient's Parent, Guardian's Signature (if child is under 18 years old) Date

Patient Consent Form
Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make the 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 use to 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

Other than your doctor, please list full name and relationship
of individual with whom we may discuss your medical condition:

_____

Patient Name: _____

Patient/patient representative Signature:

_____ _____

Signature Date

Summary of Patient's Rights and Responsibilities

We are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights and 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
- To 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 of treatment
- To select and or change your health care 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
- To keep appointments or cancel I advance\to seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

_____ _____

Signature Date

Patient Name: _____

SOCIAL SERVICES REVIEW

Patient Name: _____

Date of Birth: _____

Start of care date: _____

Services being provided are:

- ☐ Pulmonary Rehabilitation Evaluation
  (Includes: PT and RT Eval; 6 minute walk test; Spirometry)
- ☐ Physical Therapy Evaluation and Treatment
- ☐ Other: _____

REFERRING PHYSICIAN: _____

I have reviewed this patient's medical records; my recommendation is:

- ☐ There are no indications for Social Services Evaluation.
- ☐ There are indications for a Social Services Evaluation, but patient does not want to be seen at this time.
- ☐ There are indications for a Social Service Evaluation
  Patient has been contacted on _____ and an appointment has been made for _____.

Comments: _____

_____

_____

Social Services Signature: _____Date: _____

Tracy Greene-Mintz, LCSW

MEDICAL HISTORY FORM

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

PLEASE TELL US ABOUT YOUR SYMPTOMS

Age: _____

Do you get short of breath? ☐ Yes ☐ No

Activities that cause the shortness of breath:

- ☐ Walking
- ☐ Climbing Stairs
- ☐ Lying Down
- ☐ Cooking
- ☐ Dressing
- ☐ Gardening
- ☐ Exercising
- ☐ Carrying thing such as Groceries, laundry
- ☐ Talking
- ☐ Cleaning
- ☐ Personal Hygiene
- ☐ Other: _____

Does your current breathing problem affect your mood? ☐ Yes ☐ No

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

Current Living Environment:

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

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

Do you have stairs in your home; ☐ 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?_____)

Do you use Oxygen? ☐ Yes ☐ No Liter: _____ Name of Oxygen Provider:_____

- ☐ All the time
- ☐ At home only
- ☐ As needed
- ☐ At night only

Have you been hospitalized in the past year? ☐ No ☐ Yes

(If yes, please describe including approximated dates, location and reason for hospitalization)

_____**Please list the**

medications currently taken, dosage and how many times per day you take them:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have, or have you had, any of the following diagnosis or problems?

DIAGNOSIS REVIEW

Pulmonary/lungs
- ☐ Obstructive sleep apnea
- ☐ Frequent bronchitis
- ☐ Emphysema
- ☐ Frequent pneumonia
- ☐ Asthma
- ☐ Pulmonary embolism
- ☐ Tuberculosis
- ☐ ILD/Pulmonary Fibrosis
- ☐ Bronchiectasis
- ☐ Pulmonary Hypertension
- ☐ Pulmonary Edema
- ☐ Sarcoidosis

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

Muscle/joint/bone
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Rheumatoid arthritis
- ☐ Joint Replacement (where/when)
- ☐ Fractured/broken bones (specify)
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Neck/Back/Shoulders pain
- ☐ Hip/Knees/Ankles 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 mammorgram
- ☐ 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

Please describe any "yes" answers to the above questions:

_____

_____

_____

Anything else?

- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

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

_____

_____

PSYCHOSOCIAL SERVICES:

Valley Corf Inc. offers psychosocial services. Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

☐ Yes If YES, please write reason for evaluation:_____

☐ No If NO, please sign below:

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

_____

Patient's Signature (or individual completing this form for patient)

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERD 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 THE FORM.

_____ _____

Patient's Signature (or individual completing this form for patient) Date

Patient Name:_____