New Patient Registration

Today's Date:	Date of Injury:

PATIENT INFORMATION

Last Name:		First Name:	MI:
Birth date:	Age:	Sex: Male/Female	Social Security #:
Address:	Home phone:		Cell phone:
Current Occupation:	Current Employer:		Current Employer phone:

INSURANCE INFORMATION

(Please provide a photo I.D. and insurance card to the Authorization Specialist)

Insurance Carrier:	Subscriber ID:	Claim #:
Is this injury related to a motor vehicle accident?	Did this injury occur at work?	If so, employer at time of injury:
If work related, occupation at time of injury:	If work related, employer address:	If work related, employer phone number:

If work related, Nurse Case Manager/Adjustor Name & Phone/Fax:

IN CASE OF EMERGENCY

Name of local friend or relative:	Phone #:

*The above information is true to the best of my knowledge. I authorize my workers' compensation insurance benefits be paid directly to the physician and/or this medical practice. I understand that I am financially responsible for any balance. I also authorize UBYLEE or my insurance company to release any information required to process my claims.

Patient/Guardian signature　　　　　　　　　　Date

BILLING DISCLOSURES

Throughout the treatment process individuals who are directly involved in your care will sometimes call the facility to inquire about your personal health information. Please list those individuals below who are authorized to have access to your personal health information that is directly related to your current treatments at UBYLEE.

These people can include spouses, friends/roommates, children, neighbors, colleges etc.

Name: ___________________________________ Relationship:______________________

I do not want my healthcare information disclosed to the following individuals:

Name: ___________________________________ Relationship:______________________

I acknowledge that the Notice for Federal Civil Rights and The Notice of Privacy Practices is located at this UBYLEE location where I am receiving treatment. I have read these notices and understand their meaning. I can request a copy of these notices and they will be provided to me.

Signature: ________________________________ Date: _____________________________

PATIENT INJURY INFORMATION		
Did you have surgery? Yes or No	Surgeon Name?	Date of Surgery:
Diagnosis:		
Name of Referring Physician:		
Authorization Specialist Signature: ____		

CONSENT TO TREAT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NFORMATION

I, ________________________________, am fully aware of my medical diagnosis and do voluntarily and willingly consent to allow Ubylee Medical Staff and Practitioners to provide appropriate assessment, evaluation, diagnostic testing and treatment as prescribed by my Physician and/or recommended by my Physical/Occupational Therapist. I acknowledge that no specific guarantees have been issued to me regarding the successful completion or the final results of the treatment regimen prescribed or provided to me by this healthcare facility or any member of its staff. I further acknowledge and understand that the treatment I receive from Ubylee Workers Comp Healthcare Group is limited to Pain Management and/or Physical/Occupational Therapy services and should I require any additional medical treatment, diagnostics or surgical procedures outside of the scope of Ubylee's Provider parameters, I shall seek this treatment from other medical professionals/health care organizations for all other issues I may experience. I understand that I do have the right to ask any questions about my health care during the entire duration of my care under the Ubylee Workers Comp Healthcare Group. I hereby acknowledge that I have also been provided a copy of the Notice of Privacy Practices (HIPAA Privacy Rule) as well as the Notice for Federal Civil Rights and I have read and understand these notices. I also understand that I may request a copy of these notices and they will be provided to me by an Ubylee staff member.

*Signature ____ Date ________________________

Medical History Form

Patient Name :____ Date:_____________________________

Date of Birth:_______________ Height:____________ Weight:___________ Sex: Male/Female

Are you currently out of work due to your injury? Yes/No/Light duty Date of Injury: _________________________

How did the injury occur?:____

Have you had surgery for the current condition? Yes/No, If Yes, date:_______________________________________

Have you received previous treatment for the above diagnosis? Yes/No

If Yes, date and type of treatment received:____

Have you had any diagnostic testing related to this injury: NCS/EMG ____ XRAY ____ MRI ____ CT SCAN _____

Have you been diagnosed with any of the following conditions:

Condition		Condition	
Angina	YES / NO	Arthritis OA/RA	YES / NO
Panic Disorder	YES / NO	COPD	YES / NO
HIV/AIDS	YES / NO	High Blood Pressure	YES / NO
Back Injury	YES / NO	Seizures	YES / NO
Allergies	YES / NO	Pregnancy	YES / NO
Cancer	YES / NO	Tuberculosis	YES / NO
Fracture	YES / NO	Depression	YES / NO
Hypoglycemia	YES / NO	Emphysema	YES / NO
Smoking	YES / NO	Multiple Sclerosis	YES / NO
Congestive Heart Failure	YES / NO	Peripheral Vascular Disease	YES / NO
Heart Attack	YES / NO	History of Stroke	YES / NO
Pacemaker	YES / NO	Dizzy or Fainting Spells	YES / NO
Visual Impairments	YES / NO	Hepatitis A, B, C	YES / NO
Osteoporosis	YES / NO	Metal Implants	YES / NO
Diabetes	YES / NO	Loss of bowel/bladder dysfunction	YES / NO

Please indicate any other medical condition not mentioned above:

____

____

Please list the current medications you are taking:

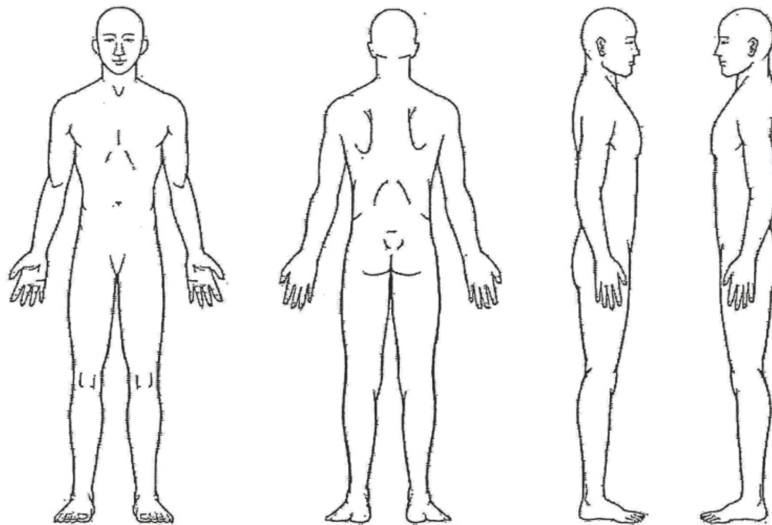
____

____

ÜBYLEE

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain

Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Describe your pain: ____

What activities that increase your pain:____

What functional tasks are you currently having difficulty with:_____________________________________

____

What are your goals: ____

____

Signature of Patient:____________________________________Date:_____________________________

Signature of Physician:__________________________________Date:_____________________________

7/10/18