



# M & M PHYSICAL THERAPY, LLC

1333 COLLEGE AVE, SUITE B SOUTH MILWAUKEE, WI 53172  
(414) 571-9146

## Patient Registration Form

Date: \_\_\_\_\_

Patient Name (first, middle initial and last): \_\_\_\_\_

Parents Name (if patient is a minor): \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Marital Status (S/M/W/D): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Whom May We Thank For Referring You: \_\_\_\_\_

Email Address: \_\_\_\_\_

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Ins Co: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

### MEDICAL HISTORY: All information is strictly confidential

Name of *primary care physician*: \_\_\_\_\_

Name of *specialist seen*: \_\_\_\_\_

Do you have or have you ever had any of the following:

\_\_\_\_\_ AIDS \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Migraine Headaches

\_\_\_\_\_ Appendicitis \_\_\_\_\_ Diabetes \_\_\_\_\_ Multiple Sclerosis

\_\_\_\_\_ Arthritis \_\_\_\_\_ Emphysema \_\_\_\_\_ Pacemaker

\_\_\_\_\_ Asthma \_\_\_\_\_ Heart Disease \_\_\_\_\_ Polio

\_\_\_\_\_ Bleeding Disorders \_\_\_\_\_ Hepatitis \_\_\_\_\_ Thyroid Problems

\_\_\_\_\_ Cancer \_\_\_\_\_ Herpes \_\_\_\_\_ Tuberculosis

\_\_\_\_\_ Chemical Dependency \_\_\_\_\_ High Cholesterol \_\_\_\_\_ Ulcers

\_\_\_\_\_ Chicken Pox \_\_\_\_\_ HIV Positive \_\_\_\_\_ Unexplained wt. Loss/gain

\_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Endometriosis \_\_\_\_\_ Hysterectomy

Other: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Describe any past serious illness or operation \_\_\_\_\_

Women Only: Are you pregnant? Yes No

Number of Children \_\_\_\_\_

<p><i>Health Habits:</i> Check which substances you use and approximately how much you use.</p> <p>_____ Caffeine _____</p> <p>_____ Drugs _____</p> <p>_____ Tobacco _____</p> <p>_____ Vitamins _____</p>	<p>How much <i>stress</i> would you describe is in your life? Mild   Moderate   Maximal</p> <p>Are you exposed to <i>hazardous</i> material at work? Yes No</p>
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### **CONSENT FOR MEDICAL SERVICES**

I, \_\_\_\_\_, hereby authorize and consent to the  
(patient / parent / guardian)  
performance of examinations, procedures, and treatments, which the attending physical  
therapists deems necessary for \_\_\_\_\_.  
(name of patient)

I hereby authorize the release of any medical information necessary to process claims and assign any benefits payable to the provider. I agree to pay for all chargers not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

I certify that the above information is correct to the best of my knowledge. I will not hold the physical therapist responsible for any errors or omissions that I may have made in the completion of the form.

This consent shall remain in effect until I choose to revoke it in writing.

\_\_\_\_\_  
Signature of Patient / Parent / Guardian

\_\_\_\_\_  
Date