



M & M PHYSICAL THERAPY, LLC

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(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 (M or S): _____

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: _____

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: _____

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 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 _____ _____ Drugs _____ _____ Tobacco _____ _____ 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
therapist 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