

PATIENT REGISTRATION

Contact Information: Name: (Last) ______ (First) _____ (MI) ____ Sex: ____ Marital Status: ____ Date of Birth: Home Address: State: Zip: City: Mobile Phone: Home Phone: Email Address: Emergency Contact: Name: _____ Relation: ____ Address: Phone: **Employer:** (If you are under 18 please list your parents' employers here) Company Name: _____ Address: _____ City: ____ Zip: _____ Work Phone: ____ Work Fax: ____ Referring Physician: Name: Address: _____ City: _____ Zip: _____ Phone: _____ Fax: _____ **Workers Comp or Auto Injury ONLY:** Date of Injury: _____ State injury occurred in: ____ Carrier: ____ Carrier Address: City: State: Zip: Case Worker: Case Worker Phone: _____ Fax Number: _____ Claim Number:

How did you hear about Ascent Physical Therapy Specialists Inc? (Circle best answer):

Doctor

Friend or Relative

Managed Care plan or list

Internet Search

Employer

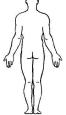
Other:

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Date: _				ASC	ENT	
Where o	did you hear abo	ut us?		Physical Speciali		
	Plea	ase check the fo	llowing conditions as the	ey apply to you:		
0 .	Allergies	0	Depression	o Multiple Sclerosis		
0 .	Anemia	0	Diabetes	o Osteoporosis		
0 .	Anxiety	0	Dizzy Spells	o Parkinsons		
	Arthritis	0	Emphysema/Bronchitis	o Rheumatoid Arthritis		
	Asthma	0	Fractures	o Seizures		
	Cancer	0	Gallbladder Problems	o Speech Problems		
	Cardiac Conditions	0	Hepatitis	o Strokes		
	Cardiac Pacemaker	0	High Blood Pressure Incontinence	Thyroid DiseaseTuberculosis		
	Chemical Dependency Circulation Problems	0	Kidney Problems	Tuberculosis Vision Problems		
	Currently Pregnant	0	Metal Implants	Vision Floorens		
Medicat	ently taking any me	——————————————————————————————————————	Y / N Dosage	Reaso	n for Takii	
Medicat	any past surgical p	procedures?	Dosage Y/N	Reaso		
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Please circle any that apply to your level of pain:

Sharp Aching Burning





Circle area of injury

Signature:	D - 4
Signature.	Date: