CHI Health

RT0010

PHYSICAL THERAPY
PATIENT REGISTRATION

If Work Comp, we also need your health insurance as a secondary policy. (It will not be billed, **UNLESS** Work Comp does **NOT** pay.)

Legal Last Name	Legal First Name	Nickname	MI

Doctor Ordering Therapy	Primary Care Physician (PCP)	Do you want notes to go to PCP, if not ordering therapy? ☐ Yes ☐ No

Legal Maiden and/or Hyphenated Name (Have you ever used another name?)	Language (if other than English)	Needs Interpreter: ☐ Yes ☐ No

Have you ever been a patient at **ANY** CHI Health Facility?
☐ Yes ☐ No ☐ Unsure

PATIENT DEMOGRAPHICS

Birth Date	Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorce ☐ Widow(er)	SSN	Home Phone ( )

Address	City	State	ZIP+4	Other Phone ( )

Employer	Race (voluntary)	Ethnicity (voluntary)

Employer Address	City	State	ZIP+4	Employer Phone ( )	Extension

Employment Student Status	Student	Religion (voluntary)
☐ Full-time ☐ Part-time ☐ Not Employed ☐ Self-employed ☐ Active Military ☐ N/A	☐ Full-time ☐ Part-time	

REQUIRED ONSET DATE (DATE PAIN STARTED) OR DATE OF MD APPOINTMENT

Onset Date	Time	State injury occurred	Type	Location
___/___/_____	_____ a.m. _____ p.m.	☐ NE ☐ IA ☐ Other _____	A = MVA, J = Job, C = Crime Victim, N = Not an Accident, L = Liability, H = Home, O = Other	H = Home, C = City Street, P = Private Property, W = Work, S = School, A = Alegent, O = Other, B = Business

IF ACCIDENT (MVA/WORK COMP)

Agent/Attorney/Other Party	Phone ( )

Work Comp (Company) Information	Claim Number

Address	City	State	ZIP+4

Comments

LATEX QUESTIONNAIRE

1. Do you have a **LATEX ALLERGY OR SENSITIVITY**? ☐ Yes ☐ No ☐ Unknown
2. Have you ever had an unexplained swelling, itching, wheezing, or hives:
   - A. Following a medical or dental procedure? ☐ Yes ☐ No ☐ Unknown
   - B. After handling rubber products, balloons, or latex gloves? ☐ Yes ☐ No ☐ Unknown
   - C. After eating tropical fruits, such as kiwis, bananas, or chestnuts? ☐ Yes ☐ No ☐ Unknown
     1) What type of reaction did you experience? _____

PRIMARY OR SECONDARY POLICYHOLDER INFORMATION (person who carries the insurance)

Relation to Patient	Birth Date	Sex ☐ Male ☐ Female	SSN	Home Phone ( )

Last Name	First Name	Middle Initial	Other Phone ( )

Address	City	State	ZIP+4

Employer	Employer Phone ( )	Extension

Employer Address	City	State	ZIP+4

EMERGENCY CONTACT

Relation to Patient	Last Name	First Name	Home Phone ( )	Other Phone ( )

Address	City	State	ZIP+4	Employer Phone ( )	Extension

MEDICARE QUESTIONNAIRE

Is the patient/spouse employed and covered by an employee group health plan? ☐ Yes ☐ No ☐ Unknown

What state did you apply for Medicare?

Prior Hospitalization	Prior Admit Date	Prior Discharge Date