MADISON MEDICAL & SPORTS rehabilitation center
AN INTEGRATIVE MEDICAL SERVICES CO.

Patient Registration

Last Name:	First Name:		Date of Birth:
Address:			Apt #:
City:	State:		Zip:
Contact #:		Gender:	Marital Status:
Email:			
Employer:		Occupation:	

Who may we THANK for referring our office?

What is your reason for visit?

How long has this been going on?

Injured? Work / School / Auto Accident / Other: N/A
How were you injured? N/A
Provider name: _____
Workers Comp Claim Opened? Y / N
Have you seen anyone else for this injury? Y/N

Did you have an MRI, X-ray or Blood Work done? Y/N Facility name: _____ (If so, please provide at visit)

Do you have a primary care physician? Y/N **Name of last physician:**
When was your last physical? **When was your last set of full blood work?**
(IF SCHEDULING WITH PT) Do you have a PT script? Y/N Referring doctor? _____Date of RX ___/____/___

Regions of Pain	**Do you now or have you ever experienced any of the following:**		**Allergies: (include reaction)**
☐ **Neck**	☐ Depression	☐ Cancer	☐ Adhesive Tape _____
☐ **Shoulder**	☐ Erectile Disfunction	☐ COVID -19	☐ Bee Stings _____
☐ **Elbow**	☐ Fatigue	☐ Diabetes	☐ Cats/Dogs _____
☐ **Hand/Wrist**	☐ Insomnia	☐ Heart Disease	☐ Iodine _____
☐ **Mid/Lower back**	☐ Low Testosterone	☐ High Blood Pressure	☐ Latex
☐ **Hip**	☐ Weight Gain	☐ High Cholesterol	☐ Penicillin
☐ **Knee**	☐ Weight Loss	☐ High Blood Pressure	☐ Seasonal (hay fever)
☐ **Ankle**	☐ Anemia	☐ Osteopenia/Osteoporosis	☐ Shellfish
☐ **Foot**	☐ Anxiety	☐ Poor Recovery/Muscle Aches	☐ Sulfa
☐ **Joint Pain**	☐ Arthritis	☐ Reflux (GERD)	☐ Other: _____
☐ **Other** _____	☐ Asthma	☐ Thyroid Condition	

Current Medications, Supplements, Vitamins and Therapies: (include over the counter medications)

Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:

Past Medications, Supplements, Vitamins and Therapies:

Name:	Dose:	Year:
Name:	Dose:	Year:
Name:	Dose:	Year:

Past Surgeries/ Illnesses: indicate year

FEMALES: Are you pregnant? YES, NO Are You Nursing? YES NO

Appt Date/Time: _____ **Doctor:_____**

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Last Name:	First Name:	DOB:

Primary Language Spoken:	Interpreter Needed: Yes No	

Social Security #:

Primary Insurance Holder Name:		Relationship: ☐ Self ☐ Spouse ☐Parent
Primary Insurance Company Name:		**PHONE #:**
Address:		Apt #:
City:	State:	Zip:
Policy Holder's Employer:		
Policy #:	Group #:	
Do you have a secondary insurance? ☐ Yes ☐ No		
Secondary Insurance Holder Name:		Relationship: ☐ Self
Secondary Insurance Company Name:		
Address:		Apt #:
City:	State:	Zip:
Policy Holder's Employer:		
Policy #:	Group #:	
Do you have an FSA, HSA or HRA? ☐ FSA ☐ HSA ☐ HRA	Plan Holder's Name: ☐ Self	
Company Name:	ID/Account number:	

Worker's Comp/Auto Insurance Information	
W/C Carrier:	Contact/Adjuster:
Claim #:	Adjuster's Phone #:

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Last Name:	First Name:	DOB:

Emergency Contact

Last Name:	First Name:	Relationship:
Home #:	Mobile #:	

Social History:			
Smoker:	Current/packs per day _____	Former/ Date quit _____	
Alcohol:	Daily/# of drinks _____	Weekly/# of drinks _____	Occasional/Social ____ Never ____
Recreational Drug Use:	Type: _____	Frequency: _____	

Circle family members with the following:					
Diabetes	Mother	Father	Sister	Brother	Grandparent
Heart Disease	Mother	Father	Sister	Brother	Grandparent
High Cholesterol	Mother	Father	Sister	Brother	Grandparent
High Blood Pressure	Mother	Father	Sister	Brother	Grandparent
Thyroid Condition	Mother	Father	Sister	Brother	Grandparent
Cancer	Mother	Father	Sister	Brother	Grandparent
Indicate Type:					
Indicate Type:					

Patients are required to complete all necessary paperwork. Changes in appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will ensure you get the treatment results you deserve. Payment is expected at the time of service in the form of cash, check, or credit card for self-pay visits and co-pays. We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient. The office is unique in its ability to offer Medical, Chiropractic, Physical Therapy, and Podiatry services. Any treatment prescribed is based on medical necessity, to resolve your condition and prevent reoccurrence.

Please feel free to ask any questions that remain unanswered. We wish to be of assistance in any way we can.

Thank you for choosing Madison Medical & Sports Rehabilitation Center for your healthcare needs!

_____

Print Patient Name

Print Name of Guardian if applicable

_____

Patient or Guardian Signature

Date