

**PERFORMANCE  
PHYSICAL THERAPY**  
OF NAPLES, INC.

Complete Orthopedic, Sports, and Spine Rehabilitation

**PATIENT REGISTRATION**

PLEASE PRINT FULL NAME \_\_\_\_\_ DATE: \_\_\_\_\_  
FIRST MI LAST NAME

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SEX: M \_\_\_ F \_\_\_ SINGLE \_\_\_ MARRIED \_\_\_ WIDOWED \_\_\_ DIVORCED \_\_\_ SEPARATED \_\_\_

LOCAL ADDRESS: \_\_\_\_\_  
P.O. BOX STREET ADDRESS CITY STATE ZIP

OUT OF STATE ADDRESS \_\_\_\_\_  
P.O. BOX STREET ADDRESS CITY STATE ZIP

HOME PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OUT OF STATE PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

WORK NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

GUARANTOR: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

ARE YOU THE PRIMARY POLICY HOLDER? YES - NO

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER SS#: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY/SUPPLEMENT INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER SS#: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

**IF THIS WAS AN ACCIDENT COMPLETE THE FOLLOWING INFORMATION:**

AUTO INSURANCE COMPANY: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

CASE ADJUSTER: \_\_\_\_\_ PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ (CIRCLE ONE): **AUTO - FALL - WORK ACCIDENT - OTHER**

NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

I understand that if I do not cancel an appointment 24 hours in advance I may be charged a \$25.00 cancellation fee.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# PERFORMANCE PHYSICAL THERAPY

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## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL CONDITION

(Circle)

	Onset		Onset
Cardiac Arrhythmia	_____	Stroke	_____
Diabetes	_____	Pacemaker	_____
Osteoarthritis	_____	Osteoporosis	_____
Asthma	_____	Other _____	_____
Cancer	_____		_____
High Cholesterol	_____		_____

### SURGICAL HISTORY

**Type of Surgery** (Circle)

	Date of Surgery		Date of Surgery
Knee surgery	_____	Back Surgery	_____
Shoulder surgery	_____	Neck Surgery	_____
CABG (open heart)	_____	Cancer removal	_____
Total Hip replacement (R or L)	_____	Other _____	_____
Total Knee replacement (R or L)	_____		_____

### MEDICATIONS

Medication currently taking:	For what reason?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### TREATMENTS RELATED TO CURRENT CONDITION:

Type of treatment (circle all that apply)	Start Date	End Date	Improved (Y or N)
Primary Physician	_____	_____	_____
Orthopedic Surgeon	_____	_____	_____
Physical Therapy	_____	_____	_____
Diagnostic Imaging (MRI, x-ray)	_____	_____	_____
Chiropractic	_____	_____	_____
Neurologist	_____	_____	_____
Physiatrist	_____	_____	_____
Massage	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____