



5899 Whitfield Ave Ste 202  
 Sarasota, FL 34243  
 Tel: 941-360-1988  
 Fax: 941-360-1998

389 Commercial Ct Ste C  
 Venice, FL 34293  
 Tel: 941-488-6600  
 Fax: 941-488-6621

**Outpatient Clinics**

**PATIENT REGISTRATION**

Medicare: \_\_\_\_ Commercial Insurance: \_\_\_\_ Auto: \_\_\_\_ Worker's Comp: \_\_\_\_ Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Other Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer name and phone #: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Specialist Physician: \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

Who referred you to Excell Rehab? Physician: \_\_\_\_ Friend: \_\_\_\_ Yellow Pages: \_\_\_\_ Other: \_\_\_\_\_

Have you had Physical, Occupational or Speech Therapy since January, 2010? \_\_\_\_\_

If you are coming to therapy due to auto or work related accident, what was the date of your injury? \_\_\_\_\_

Are you currently or have you been followed by a Home Health Agency? \_\_\_\_\_

If so, please specify which Home Health Agency and how many visits? \_\_\_\_\_

Name of Guarantor if other than patient \_\_\_\_\_ Parent \_\_\_\_ Guardian \_\_\_\_ Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_

**\* Please give the receptionist your health insurance cards and a photo ID.**

**Patient's Signature:** \_\_\_\_\_

**MEDICAL INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Method of Injury: \_\_\_\_\_

Medications: \_\_\_\_\_

Check medical conditions you have been treated for:

- |                                               |                                                   |                                                    |
|-----------------------------------------------|---------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Neurological Problems     |
| <input type="checkbox"/> Cardiac Problems     | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Pacemaker / Defibrillator |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Incontinence             | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Cancer / Type: _____ | <input type="checkbox"/> Joint Replacement: _____ |                                                    |

Any surgeries related to above conditions? \_\_\_\_\_

Activities prior to injury/surgery: Occupational:  light     moderate     heavy     N/A  
 Recreational:  light     moderate     heavy     N/A

Current activities: Occupational:  light     moderate     heavy     N/A  
 Recreational:  light     moderate     heavy     N/A

What is the location of the pain or discomfort we are seeing you for? \_\_\_\_\_

Pain/discomfort is:  constant     intermittent     dull     sharp  
 shooting     burning     throbbing     other: \_\_\_\_\_

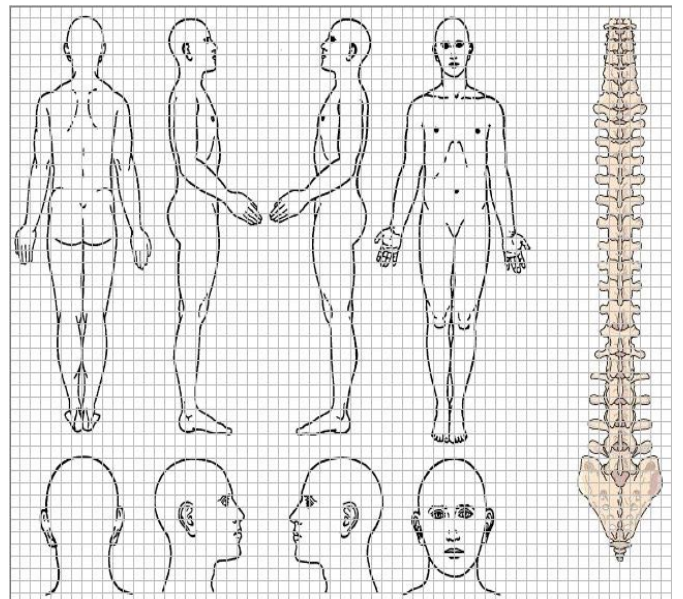
Please rate your pain on a scale of 0 to 10  
 (0= no pain, 10= worse pain)

0    1    2    3    4    5    6    7    8    9    10

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Please use the body chart on the right to indicate the location of your symptoms (xxx = pain    ooo = numbness or tingling)



Patient's Signature: \_\_\_\_\_



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Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance name: \_\_\_\_\_ Ins ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ SS #: \_\_\_\_\_

I hereby instructed and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to: Maxider Corporation, PO Box 21075, Sarasota, FL 34276.

Or, if my current policy prohibits direct payment to provider, I hereby also instruct and direct \_\_\_\_\_ Insurance Company to make out the check to me and mail it as follows:

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

I authorize treatment, and agree to allow Excell Rehab to file claims to the insurance company on my behalf. Excell Rehab will file claims to insurance accordingly, however, if payment is not received within 60 days, the balance will be my responsibility (Workman Comp and Auto Insurance with LOP are exempt). **It is my responsibility to know and understand my insurance benefits. This includes deductibles, participating providers, limitations on payments, number of visits, co-pays and co-insurance information. Any balance not paid by my insurance is my responsibility.** If the insurance company reimburses me for services provided by Excell Rehab, it is my responsibility to sign over check to "Maxider Corporation" and send to its office along with payment statement.

I also am authorizing the release of any information on my treatment that may be required to process my claim to any insurance company, attorney and/or physician.

***Please respect your appointment time. If you are unable to make it, please notify us 24 hours in advance. A \$25 fee will be charged for NO SHOWS. Thank you.***

By signing below, I agree in all above statements regarding my insurance benefits and also I acknowledge that I received the **NOTICE OF PRIVACY PRACTICE** and have had an opportunity to read it.

Patient's Signature \_\_\_\_\_  
Policyholder

Date: \_\_\_\_\_

Claimant Signature: \_\_\_\_\_  
If other than Policyholder

Date: \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_

Date: \_\_\_\_\_