75 Independence Way
Suite 30204
Cranston, RI 02921

Home Physical Therapy℠
for Seniors

866-4-HOME-PT
Local: 401-536-4117
Fax: 401-943-2484

New Patient Registration Form

Last Name: (Mr., Mrs., Ms.) ___________________________ First Name: _________________________ M.I.: ______

Home Phone: _____________________________________ Cell Phone: _______________________________________

Address: ____

City: __________________________________ State: ______________________ Zip: __________________________

E-mail: ____

Date of Birth: ____________________________(mm/dd/yyyy) SSN: ____

___ Single ___ Married ___ Student

Employer: ____ Phone: _____________________________________

Address: ____

City: __________________________________ State: ______________________ Zip: ___________________________

Job Title/Position: ____ Shift: __________________________

REFERRAL:

Referring Physician Name: ____ Phone: ________________________

Address: ____

City: __________________________________ State: ______________________ Zip: ___________________________

Next MD Appointment: _________________ PCP Name (if different): ____

Other Treating Physician's: ____

MEDICAL HISTORY:

Please list current medications including vitamins and over-the-counter medications:

____

____

____

____

Surgeries:

____

____

____

Allergies:

____

____

Do you smoke: ___________________ Packs per day: _____________

Do you have any of the medical conditions listed below? Please select if positive:

___ Cardiac Condition ___ Diabetes ___ Asthma ___ Cancer ___ High Blood Pressure

Fall Risk Intake:

Do you experience unsteadiness or loss of balance while walking? ________________________

Have you fallen in the past year: ___________ If yes, how many times: ___________________

If yes, what was/were the date(s) of your fall? ____

Do you experience dizziness or vertigo? ____

Do you have an ongoing 3rd party litigation for this condition: ___ Employment ___ Automobile Accident

WORKERS' COMPENSATION OR AUTO INSURANCE INFORMATION:

Insurance Company Name: ____ Claim #: ____________________

Address: ____

City: ______________________________ State: ___________________ Zip: ________________________

Claim Representative: ________________________________ Phone: ________________________________

Date of Accident/Injury: ______________________(mm/dd/yyyy)

State of Accident/Injury: _________________________________

PRIMARY MEDICAL INSURANCE:

Insured Person's Name: _________________________________ Phone: ______________________________

Address: ____

City: ______________________________ State: ___________________ Zip: ________________________

Date of Birth: _________________________(mm/dd/yyyy) SSN: _____________________________________

Employer: ____

Relationship to patient: ___ Self ___ Spouse ___ Parent

SECONDARY MEDICAL INSURANCE:

Insured Person's Name: _________________________________ Phone: ______________________________

Address: ____

City: ______________________________ State: ___________________ Zip: ________________________

Date of Birth: __________________________(mm/dd/yyyy) SSN: ______________________________________

Employer: ____

Relationship to patient: ___ Self ___ Spouse ___ Parent

Patient's or Guardian's Signature: I authorize the release of any medical or other information necessary to process this claim.

Signature: ____ Date: ______________________(mm/dd/yyyy)

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Home Physical Therapy for Seniors for physical therapy services provided to patient.

Signature: ____ Date: ______________________(mm/dd/yyyy)