

**ORCAS ISLAND PHYSICAL THERAPY, PLLC / PATIENT REGISTRATION**

LAST NAME:		FIRST NAME:		INITIAL:
ADDRESS:			HOME PHONE:	
CITY:	STATE:	ZIP:	WORK PHONE:	
EMAIL ADDRESS FOR APPTS & CANCELLATIONS:				
SOCIAL SECURITY #:		DATE OF BIRTH: ___/___/___		
MALE / FEMALE		MARRIED / SINGLE / WIDOWED / DIVORCED / DEPENDENT		
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:		
EMERGENCY CONTACT:		PHONE:		

<b>TYPE OF INSURANCE:</b> (CIRCLE / ENTER ALL THAT APPLY)	MEDICARE
	SECONDARY:
<b>L &amp; I:</b>	GROUP HEALTH / MEDICARE or STERLING / MEDICARE
CLAIM #:	PRIVATE INSURANCE:
DATE OF INJURY:	SELF PAYING

NAME OF EMPLOYER WHEN ACCIDENT OCCURRED: \_\_\_\_\_

Motor Vehicle Accident Insurance Co: \_\_\_\_\_

**For Medicare Patients:**

Have you received physical therapy, occupational therapy or speech therapy this calendar year? Yes / No  
If yes, when: \_\_\_/\_\_\_/\_\_\_ and where: \_\_\_\_\_

**Please note: Unless you are ill or have an emergency, kindly allow us 24 BUSINESS hours to give your cancelled appt to another in need.**

**MEDICAL INFORMATION**

**REASON FOR YOUR VISIT TODAY:**

List any prescription medications you are taking: \_\_\_\_\_

List any allergies you may have to Latex, tape adhesives, lotions, creams or topical medications (IE: Fluocinonide or Dexamethasone): \_\_\_\_\_

List any prior surgeries and/or physical therapy: \_\_\_\_\_

**Please check any of the following that pertain to you, historically and/or currently:**

<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	HIV
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Pregnancy (current)
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	HEP B	<input type="checkbox"/>	TB
<input type="checkbox"/>	HEP C	<input type="checkbox"/>	Other: