ORCAS ISLAND PHYSICAL THERAPY, PLLC

PATIENT REGISTRATION

DATE: _____

LAST NAME: _____ BILLING ADDRESS: _____

FIRST NAME: _____ CITY: _____

M INITIAL: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

HOME PHONE: _____ WORK PHONE: _____

MARRIED / SINGLE / WIDOWED / DIVORCED / DEPENDENT

EMERGENCY CONTACT: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

IF LABOR & INDUSTRY, CLAIM #: _____

IF MOTOR VEHICLE ACCIDENT, NAME OF INSURANCE: _____
CLAIM #: _____ NAME OF REP: _____

LIST WHERE AND HOW MANY PT, OT OR ST VISITS YOU MAY HAVE HAD DURING THIS, YOUR INSURED CALENDAR YEAR:

SOME OF THE INGREDIENTS, BELOW, MAY BE USED IN YOUR TREATMENTS. CIRCLE ANY THAT YOU MAY BE ALLERGIC TO:

Sulfa Latex Tape adhesives Lotions, Creams or Topical Medications (ie: Fluocinonide or Dexamethasone)

LIST PRESCRIPTION MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

CHECK ALL CONDITIONS THAT MAY APPLY:

ARTHRITIS	HEART DISEASE	PACEMAKER
ASTHMA	HEP B	PREGNANCY
CANCER	HEP C	SHORTNESS OF BREATH
CHEST PAIN	HIGH BLOOD PRESSURE	STROKE
DIABETES	HIV	TB
DIZZINESS	IRREGULAR HEART BEAT	OTHER:

LIST PRIOR SURGERIES:

PLEASE, UNLESS YOU ARE ILL OR HAVE AN EMERGENCY, KINDLY ALLOW US A FULL BUSINESS DAY TO GIVE YOUR CANCELLED APPOINTMENT TO ANOTHER IN NEED.

NOTE: THERE IS A $50.00 CHARGE FOR LATE CANCELLATION OR NO SHOW