GOLDMAN PHYSICAL THERAPY

LOCATED AT THE GYM

20 Nordhoff Place, 2nd Flr Englewood, NJ 07631 Tel: (646) 406-5994 Fax: (201) 567-9394

PATIENT REGISTRATION

Name:_____ **Soc. Sec #:**_____-_____-_____

Age:_____ **Date of Birth**:_____/_____/_____ **Gender: Male Female**

Address:_____**Apt.#**_____

City:_____ **State**: **Zip** _____:_____

Telephone #'s: Home:_____-_____-_____

Work:_____-_____-_____

Cell:_____-_____-_____

May Goldman Physical Therapy contact you at any/all of these telephone numbers?* **YES / NO

How did you hear of our rehab facility?_____

EMPLOYMENT INFORMATION

Employer:_____

Address:_____

Occupation:_____

INSURANCE INFORMATION

Primary Insurance:_____ **ID #**:_____

Are you the Primary Insurance Policy Holder? YES / NO ***If you circled NO, please fill out***

Primary Policy Holder Name:_____

Date of Birth:_____/_____/_____ **Soc. Sec.#**:_____-_____-_____

Secondary Insurance:_____ **ID #**:_____

Are you the Secondary Insurance Policy Holder? YES / NO ***If you circled NO, please fill out***

Secondary Policy Holder Name:_____

Date of Birth:_____/_____/_____ **Soc. Sec.#**:_____-_____-_____

WORKER'S COMPENSATION & AUTOMOBILE ACCIDENT CASES:

Case Manager:_____ **Tel. #**:_____

WCB/ Case Number:_____**Date of Occurance**:_____/_____/_____

MEDICAL DOCTOR INFORMATION

Primary Doctor:_____ **Referring Doctor**:_____

Address:_____ **Address**:_____

Tel #:_____-_____-_____ **Tel #**:_____-_____-_____

UPIN #:_____ **UPIN #**:_____

MEDICAL HISTORY

Do you have or have you had any of the following diseases, medical conditions, or procedures/surgery?

Y N Heart Attack/ Stroke	**Y N** Thyroid Problem	**Y N** Cancer/ Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./ Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray/ Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/ AIDS/ ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Breathing Difficulty
Y N Artificial Valves	**Y N** Stomach Pains/ Ulcers	**Y N** Artificial Joints/ Bones	**Y N** Diabetes
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/ Seizures	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/ Drug Abuse	**Y N** Severe/ Freq. Headaches	**Y N** High/ Low Blood Press.
Y N Scarlet Fever	**Y N** Tuberculosis	**Y N** Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Pain/ TMJ/ TMD	**Y N** Back Pain	**Y N** Glaucoma

Please list below any other relative surgeries or medical conditions you have or ever had:

_____

Are you taking any medications relative to your condition? If yes, please list below:

_____

Briefly describe your injury/ illness including dates of occurrence, involved body parts, surgeries, and any recent attempted treatments: _____

_____

_____

_____

_____

**I authorize Goldman Physical Therapy , LLC to treat me as per my doctor's prescription and to release to my insurance company or lawyer, any information concerning health care, advised treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims for benefits. I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and will notify office of any information changes.

Signature:_____ **Date**:_____

Print Name:_____