GLICK
Physical Therapy, PC

Patient Registration Form

444 W Jericho Tpke
Huntington, NY 11743
Phone: 631-659-3800
Fax: 631-659-3798
www.glickpt.com

PATIENT INFORMATION

Patient Name:		
Date of Birth:		
Address:		
City:	State:	Zip Code:
Home Phone:		
Office Phone:		
Cell Phone:		
Email Address:		
Gender:		
Primary Physician:		
Referring Physician:		
Body Part / Surgery:		
Date & Time of Evaluation		
Who Can We Thank For Referring You?		

EMERGENCY CONTACT

Name:
Relationship:
Phone:

PRIMARY INSURANCE

Insurance Company:
Subscriber ID #:
Group #:
Phone:

SECONDARY INSURANCE

Insurance Company:
Subscriber ID #:
Group #:
Phone:

WORKER'S COMP/NO FAULT

Insurance Company:
Contact Person:
Claim #:
Policy #:
Date of Injury/Accident:
Other:

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Glick Physical Therapy, PC. In doing so, I understand that such rehabilitation and related services may involve bodily contact or palpation.

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive my claim I may have from failure to do so.

LIABILITY: I know and agree that Glick Physical Therapy, PC is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit Glick Physical Therapy, PC, it's agents, representatives, affiliates, employees or assigns, of and from any and all liability, claim, demand, damage case of, action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow, emergency or medical services, including but not limited to ambulance service, EMT, physician or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Glick Physical Therapy, PC and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or requested in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY: I have read the Notice of Privacy Practices and fully understand its contents.

Signature ***Date***

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Medical History Form

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NAME:	Date of Birth:
What is your chief complaint?	Date Symptoms Started:

INJURY CAUSE: (check one)

- ☐ No specific injury
- ☐ Fall
- ☐ Lifting
- ☐ Sports
- ☐ Motor vehicle accident
- ☐ Work injury
- ☐ Post-surgery

PAIN & FUNCTION

Pain level (circle): ☐ 0-(None) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Location:

SYMPTOMS: (check all that apply)

- ☐ Pain
- ☐ Stiffness
- ☐ Weakness
- ☐ Numbness / Tingling
- ☐ Swelling
- ☐ Balance problems
- ☐ Difficulty walking

ACTIVITIES LIMITED BY YOUR PROBLEM:

- ☐ Walking
- ☐ Standing
- ☐ Stairs
- ☐ Sleeping
- ☐ Lifting
- ☐ Reaching overhead
- ☐ Sitting
- ☐ Sports / Recreation

MEDICAL CONDITIONS: (check all that apply)

- ☐ None
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart failure
- ☐ Atrial fibrillation
- ☐ Stroke / TIA
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy
- ☐ COPD / Emphysema
- ☐ Asthma
- ☐ Cancer (current or history)
- ☐ Chronic kidney disease
- ☐ Thyroid disease
- ☐ Depression / Anxiety
- ☐ Obesity
- ☐ Other:

ORTHOPEDIC SURGERY HISTORY:

- ☐ None
- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Rotator cuff repair
- ☐ ACL reconstruction
- ☐ Meniscus surgery
- ☐ Shoulder replacement
- ☐ Spinal surgery (fusion / discectomy)
- ☐ Ankle surgery
- ☐ Other:

SAFETY & HEALTH ALERTS:

- ☐ Pacemaker
- ☐ Blood thinner medication
- ☐ History of falls
- ☐ Dizziness / vertigo
- ☐ Shortness of breath
- ☐ Pregnancy

CURRENT MEDICATIONS:

☐ See medication list provided

OR List:

PATIENT GOALS:

What do you want to get back to doing?

Patient Signature ***Date***