Dedham Health Physical Therapy (DRAC Physical Therapy)
https://dedhamhealthphysicaltherapy.com/
Patient Registration Form
Please Print Clearly

PATIENT INFORMATION

TODAY'S DATE: ___/___/___

LAST NAME: _____FIRST NAME:_____MI:_____

DATE OF BIRTH:_____/_____/_____ SEX: ☐ M ☐ F

HOME ADDRESS: _____

CITY:_____ STATE:_____ZIP CODE: _____

HOME PHONE:_____CELL PHONE: _____

EMPLOYED: ☐ YES ☐ NO RETIRED: ☐ YES ☐ NO STUDENT: ☐ YES ☐ NO

EMPLOYER/SCHOOL: _____WORK PHONE: _____

EMAIL ADDRESS: _____

IN CASE OF EMERGENCY CALL:

NAME: _____ TEL. NUMBER#: _____

HOW WOULD YOU LIKE TO BE REMINDED OF YOUR APPOINTMENT?

☐ PHONE CALL: (_____)_____-_____

☐ TEXT MESSAGE: (_____)_____-_____

☐ EMAIL: _____@_____.COM

DOCTOR'S INFORMATION

REFERRING DR/SPECIALIST: _____

PHONE NUMBER: _____

PRIMARY CARE DR: _____

PHONE NUMBER: _____

HAVE YOU HAD PHYSICAL THERAPY WITHIN THE PAST 365 DAYS? ☐ YES ☐ NO

IF YES, HOW MANY VISITS: _____

IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO

IS THIS INJURY A RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

PATIENT INFORMATION

NAME: _____OCCUPATION:_____AGE:_____

HEIGHT: _____FT____IN WEIGHT:_____

DO YOU NOW, OR HAVE YOU EVER HAD ANY MEDICAL ISSUES/CONDITIONS AND/OR SURGERY? (IF YES, PLEASE LIST BELOW)

_____

_____

_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? IF YES, PLEASE LIST THE MEDICATION NAME BELOW. (USE THE BACK SIDE IF NEEDED OR PROVIDE LIST)

_____

_____

_____

Please rate your pain on a scale from 0-10 (0 being no pain, 10 being emergency room pain):

0----1----2----3----4----5----6----7----8----9----10

At Worst, My Pain Is: ___/10 **My Current Pain Is: ___/10** **At Best, My Pain Is: ___/10**

How would you describe your pain (please circle):

Deep/Achy	Throbbing	Sharp	Electric	Burning	Pins/Needles
Shooting	Worse in AM	Worse in PM	Constant	Intermittent	Dull/Sore

WHERE IS YOUR PAIN LOCATED?_____

_____

DATE OF ONSET/INJURY:_____

HOW DID THIS INJURY OCCUR? _____

_____

_____

_____

_____

PATIENT NAME: _____ TODAY'S DATE: ___/___/___

INSURANCE INFORMATION

* FAILURE TO PROVIDE ALL NEEDED INSURANCE INFORMATION RESULTS IN CHARGES DIRECTLY TO THE PATIENT OR GUARANTOR**

PRIMARY INSURANCE: _____ ID#: _____

GROUP# (if applicable):_____POLICY HOLDER:_____

POLICY HOLDER DOB: ____/____/____ RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE: _____ ID#: _____

GROUP# (if applicable):_____POLICY HOLDER: _____

DOB: ____/____/____ RELATIONSHIP TO POLICY HOLDER: _____

IF YOU HAD A CAR OR WORK RELATED ACCIDENT PLEASE COMPLETE THIS SECTION:

If **Work** related see section 1, If **Auto** related skip to section 2

Section 1-Workers Compensation Claims

DATE OF ACCIDENT: _____CLAIM NUMBER: _____

Name of Employer: _____ Phone: _____

Insurance Company Name: _____

Address of Insurance Company: _____

Claims Adjuster: _____ Adjuster Phone Number: _____

Section 2- Motor Vehicle Claims **(Note all Motor Vehicle cases must also provide health insurance information)**

DATE OF ACCIDENT: _____CLAIM NUMBER:_____

Insurance Company Name:_____

Address of Insurance Company:_____

Claims Adjuster:_____ Adjuster Phone Number:_____

Have you returned your PIP Application to Insurance Company? Yes_____ No_____

Have you exhausted your PIP yet? Yes_____ No_____

Lawyers Name and Phone Number: _____