HAWAII PHYSICAL THERAPY, INC. -- PATIENT REGISTRATION FORM

Please fill out this form to register as a patient of Hawaii Physical Therapy, Inc. All fields with an asterisk (*) are REQUIRED. We cannot register you as a Hawaii Physical Therapy, Inc. patient without this information.

PATIENT INFORMATION

*Name: LAST FIRST M.I. (,)		Account Number:	*SSN:
*Gender: Male ☐ Female ☐	*Date of Birth:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	
*Address:		*City:	*State: HI / *Zip Code:
*Home Phone:	Alternate Phone:	Driver License No.:	Email Address:
*Employer/School:		Employ Status: FT ☐ PT ☐ Not Employed ☐ Retired ☐ Active Duty ☐ Self ☐	
Address:		City:	State: / Zip Code:
Work Phone:	Occupation:		Student Status: FT ☐ PT ☐
*Is this injury related to a Work or Auto accident? Yes ☐ No ☐			Date of Injury:

GUARANTOR INFORMATION (person that is responsible for the bill)

*Name: LAST FIRST M.I.		*Date of Birth: / /	*SSN: - -
*Address:		*City:	*State: / *Zip Code:
*Home Phone: ( ) -	*Relationship to Patient:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	

INSURANCE COVERAGE & SUBSCRIBER INFORMATION (person that has the insurance policy)

*Primary Insurance Name:		*Subscriber's Name: LAST FIRST M.I. (,)	
*Gender: Male ☐ Female ☐	*Date of Birth:	*SSN:	* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:
Secondary Insurance Name:		*Subscriber's Name: LAST FIRST M.I. (,)	
*Gender: Male ☐ Female ☐	*Date of Birth:	*SSN:	* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:
Tertiary Insurance Name:		*Subscriber's Name: LAST FIRST M.I. (,)	
*Gender: Male ☐ Female ☐	*Date of Birth:	*SSN:	* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:

*Emergency Contact:	*Relationship to Patient:	*Phone No.: ( ) -
If patient is a child, who may authorize treatment for this child?	Relationship to Patient:	Phone No.: ( ) -
Nearest friend or relative not residing with you:	Relationship to Patient:	Phone No.: ( ) -

Do you have a telephone answering machine or voicemail in your home? Yes ☐ No ☐
If so, may we leave messages from this office on that machine? Yes ☐ No ☐
May we contact you at work and/or leave messages there? Yes ☐ No ☐

Who is your Primary Care Physician (PCP)?

Do you authorize release of your medical information to anyone besides your insurance carrier(s)? Yes ☐ No ☐
If so, whom?

HAWAII PHYSICAL THERAPY, INC.

Medical History Form

Name:

Referring Physician:

Family Physician: ______________________

Date of 1st Doctor visit for this injury/illness: ______________

Last day worked due to this injury: ______________

Date returned to work after this injury: ______________

Is an Attorney involved in this case? ☐ Yes ☐ No

Since what Date: ______________________

Have you had Surgery for this injury? ☐ Yes ☐ No

Date/Type of surgery: ______________________

Are you or do you think you might be pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you Currently taking ANY prescription or Non-prescription medication? ☐ Yes ☐ No

If yes, please list medications: ______________________________________

Have you had any of the following Services for this injury/illness? (Please mark all that apply)

- ☐ Physical Therapy
- ☐ Emergency Room Care
- ☐ MRI
- ☐ Orthopedist
- ☐ X-rays
- ☐ Neurologist
- ☐ Chiropractic
- ☐ CT Scan
- ☐ Other: ______________

Do you now have or have you EVER had ANY of the following? (Please mark all that apply)

- ☐ Heart problems or surgery
- ☐ Osteoprosis
- ☐ Diabetes
- ☐ Cancer/Tumor
- ☐ High Blood Pressure
- ☐ Stroke / TIA
- ☐ Seizures / Epilepsy
- ☐ Hernia
- ☐ Numbness or tingling
- ☐ Allergies
- ☐ Joint replacement
- ☐ Bowel or bladder problems
- ☐ Asthma or other breathing problems
- ☐ Emotional/Psychological problems
- ☐ Dizziness or Fainting
- ☐ Thyroid/Goiter problem
- ☐ Migraines
- ☐ Vision or hearing problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Weakness
- ☐ Vericose veins
- ☐ Shortness of breath or chest pain
- ☐ Pacemaker/Nitroglycerin patch
- ☐ Gout
- ☐ Infectious disease
- ☐ Sleeping problems
- ☐ Weight or energy loss
- ☐ Any type of implants
- ☐ Neck injury/surgery
- ☐ Back injury/surgery
- ☐ Shoulder injury/surgery
- ☐ Hip/knee injury/surgery
- ☐ Elbow/wrist/hand injury/surgery
- ☐ Leg/Ankle/Foot injury/surgery

Please add any other information that you think would be helpful: ______________________________

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Has your physician made you aware of the Diagnosis you are being treated for? ☐ Yes ☐ No

What are your expectations/goals for Physical Therapy? ______________________________

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Patient/Guardian Signature: ______________________ Date: ______________

This form has been reviewed by: ______________________ Date: ______________