FORT LEE PHYSICAL THERAPY 301 BRIDGE PLAZA NORTH, FORT LEE, NJ 07024
PATIENT REGISTRATION FORM (PLEASE PRINT CLEARLY)

Workers Compensation Section: ***Please complete if your injury is work-related.***	
Workers Compensation Claim Number	
Workers Compensation Insurance Company Name	
Claim Adjuster's Name	Billing Address
Adjuster's Phone Number ( ) ext.	
No Fault/Motor Vehicle Accident (MVA) Section: ***Please complete if your injury is MVA-related.***	
Auto Insurance Company Name	
Policy Number	Policy Date
Name of Insured Policyholder, if not yourself	
Claim Number	
Claim Adjuster's Name	Billing Address
Adjuster's Phone Number ( ) ext.	
In the accident, you were (circle): Driver Passenger Pedestrian	
What was the state in which the accident occurred?	
Do you live with the owner of the car that was involved in the accident?	
If applicable, please provide attorney information:	
Attorney Name	Phone Number ( )
Address	

	PATIENT MEDICAL HISTORY **Medical Condition – English/Spanish**	**PLEASE CIRCLE**
1.	History of Heart Problems / Historia de Problemas Cariacos	YES or NO
2.	Pace-Maker / Marka-Pasos (De Corazon)	YES or NO
3.	High Blood Pressure / Presion Alta	YES or NO
4.	Cancer / Cancer	YES or NO
5.	Tumors or Cysts Removed / Tumores o Lunares Malignos Extraidos	YES or NO
6.	Tuberculosis / Tuberculosis	YES or NO
7.	Skin Disorders / Desordenes de la Piel	YES or NO
8.	HIV Positive / SIDA	YES or NO
9.	Lung Disease / Problemas Pulmonares	YES or NO
10.	Asthma / Asma	YES or NO
11.	Are you presently pregnant / Esta ahora Embarasada?	YES or NO
12.	Headaches / Frecuente Dolores de Cabeza	YES or NO
13.	Dizziness / Mareos	YES or NO
14.	Blurred Vision / Vision Nublada	YES or NO
15.	Vomiting or Nausea / Frecuente Vomito o Nausia	YES or NO
16.	Numbness / Falta de Sensacion	YES or NO
17.	Arthritis / Artritis	YES or NO
18.	Osteoporosis / Osteoporosis	YES or NO
19.	Internal Implants (Metal or Plastic) / Implantes Internos (de Metal o Plasticos)	YES or NO
20.	Diabetes / Diabetis	YES or NO
21.	Hepatitis / Hepatitis	YES or NO
22.	Circulation Problems / Problemas con la Ciculacion	YES or NO
23.	Sensitivity to Heat or Ice Pack / Sensibilidad al Calor o al Frio	YES or NO
24.	Other – please specify: _____	

Patient Signature: _____ Date: _____