New Patient Information Sheet

Date:_____

Name: _____

Address: _____

_____

Phone: _____

Date of Birth: _____

Referring MD: _____

Medical History:

Please check if any of the following apply:

Arthritis	
Asthma	
Cancer	
Cardiac / Heart Condition	
Diabetes	
Fractures	
High Blood Pressure	
Osteoporosis	
Seizures	
Stroke	
Pain	

Please Describe any other conditions / precautions we should be aware of:

_____

_____

Current Medications:

In case of Emergency, who should we contact?

Name:_____

Phone:_____

Please bring all insurance cards and valid form of identification to your appointment.

Authorization to bill:

I authorize Occupational Therapy of Delaware to submit claims on my behalf. I authorize the release of information necessary to process my claims.

Signature: _____

Date:_____