Heights Hand Therapy OT
Hand & Upper Extremity Rehabilitation, PLLC

50 Court Street, Suite 1208
Brooklyn, NY 11201

Tel: 718-875-4030
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heightshandtherapyOT@aol.com

PATIENT REGISTRATION FORM

Last Name: _____ _____ First Name: _____ MI: _____

Address: _____ City: _____ State _____ Zip: _____

Home Telephone No: (_____) _____ Cell Phone (_____) _____

Work Telephone No: (_____) _____ DOB: _____/_____/_____

E-Mail Address: _____

Occupation:_____ SSN: _____

Place of Employment: _____ Address: _____

Marital Status: ( ) Married ( ) Divorced ( ) Single ( ) Significant other City, State, Zip: _____

In case of emergency, please notify: _____ Relationship _____

Telephone No: (_____)_____

Beneficiary Medical History: _____

ALLERGIES: _____ **MEDICATIONS:** _____
(Attach separate list if necessary)

RESPONSIBLE PARTY (PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT) ***COMPLETE ONLY IF THAT PERSON IS OTHER THAN THE PATIENT. PERSON UNDER 18 YEARS REQUIRES A PARENT PRESENT.***

Last Name: _____ _____ First Name: _____ MI: _____

Address: _____ City: _____ State _____ Zip: _____

Home Telephone No: (_____) _____ Work Telephone No: (_____) _____

DOB: _____/_____/_____ SSN: _____

Relationship to patient: _____

OFFICE POLICIES:

- PLEASE BRING A PHOTO ID REQUIRED TO ENTER THE BUILDING.
- PLEASE NOTIFY THE OFFICE WITHIN 24 HOURS IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.
- PAYMENT IS EXPECTED AT THE TIME OF VISIT FOR ALL CO-PAYS AND NON-INSURANCE PATIENTS.
- ALL RETURNED CHECKS WILL BE ASSESSED A $20.00 FEE REGARDLESS OF THE REASON