BRIDGEPORT PHYSICAL THERAPY

PATIENT INFORMATION

NAME:_____ _____SSN:_____-_____-_____
FIRST LAST MI (SUFFIX)

ADDRESS:_____
HOME STREET ADDRESS CITY STATE ZIP CODE

☐ MALE ☐ FEMALE DATE OF BIRTH____/____/_____ MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐ WIDOWED

Student Status:☐ Full Time ☐ Part Time ☐ Employed Name of School:_____

E-MAIL ADDRESS:_____Fax:(___)___-_____MAY WE LEAVE A MESSAGE ON ANSWERING MACHINE:_____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS BY E-MAIL: ☐ Yes, Notify me by email ☐ No,Do not email me

HOME PHONE(_____)_____WORK PHONE(_____)_____CELL PHONE(____)_____

EMERGENCY CONTACT NAME:_____PHONE:(_____)_____RELATIONSHIP TO PATIENT_____

WHO MAY WE DISCUSS YOUR MEDICAL CONDITION WITH?_____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDER BY TEXT: ☐ YES, NOTIFY ME BY TEXT ☐ NO, DO NOT TEXT ME.

Driver's License#:_____State Issued:_____**Please provide a copy for our records**

EMPLOYER:_____OCCUPATION:_____

REFERRING PHYSICIAN:_____DATE SEEN:_____NEXT SCHEDULED APPOINTMENT:_____

DOCTOR OFFICE ADDRESS:_____PHONE: (_____)_____

APPOINTMENT POLICY

I UNDERSTAND THAT MY DOCTOR HAS PRESCRIBED THERAPY FOR ME AND THAT PHYSICAL THERAPY IS AN ON-GOING PROCESS WHICH REQUIRES REGULAR ATTENDANCE TO BE OPTIMALLY EFFECTIVE. I UNDERSTAND THAT IF I AM LATE FOR AN APPOINTMENT, I MAY NEED TO RESCHEDULE MY APPOINTMENT OR MAY HAVE TO ACCEPT AN ABBREVIATED TREATMENT FOR THAT DAY. I UNDERSTAND THAT IF I CANCEL OR NO-SHOW FOR THREE CONSECUTIVE APPOINTMENTS, BRIDGEPORT PHYSICAL THERAPY HAS THE RIGHT TO DISCHARGE ME FROM CARE FOR BEING NON-COMPLIANT WITH MY PHYSICIAN ORDERS.

✓ **SIGNATURE**:_____DATE:_____

(PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OR SEEN THE "CONSENT FOR TREATMENT" &"NOTICE OF PRIVACY PRACTICE. "I UNDERSTAND THAT I MAY ASK QUESTIONS ABOUT THE "CONSENT FOR TREATMENT" OR "NOTICE OF PRIVACY PRACTICES" AT ANY TIME.

✓ **PATIENT/PARENT/GUARDIAN SIGNATURE**_____DATE:_____

WITNESS:_____

BRIDGEPORT PHYSICAL THERAPY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

I UNDERSTAND AND AGREE AND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES OR ANY PROFESSIONAL SERVICES RENDERED THAT IS NOT COVERED BY MY INSURANCE CARRIER. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS MY CLAIN. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I UNDERSTAND THAT I AM RESPONSIBLE TO INFORM THE OFFICE OF ANY CHANGES THAT OCCUR IN MY HEALTH STATUS OR BILLING INFORMATION. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BRIDGEPORT PHYSICAL THERAPY SERVICES, INC. REGARDLESS OF PARTICIPATION IN OR OUT-OF-NETWORK, INCLUDING MEDICARE. SHOULD I DEFAULT ON MY FINANCIAL RESPONSIILITY AND COLLECTION ACTIONS IS NECESSARY, I WILL BE RESPONSIBLE FOR COLLECTION COSTS THAT ARE INCURRED. THIS IS TO INFORM ANY PATIENT COVERED BY MEDICARE BENEFITS THAT ONLY SERVICES THAT IS DETERMINED TO BE "REASONABLE AND NECESSARY" UNDER SECTION 18662(a)(1) OF THE MEDICARE LAW WILL BE PAYABLE.

ALL RECORDS WILL BE KEPT ON FILE IN OUR OFFICE FOR A TEN (10) YEAR PERIOD PRIOR TO DESTROYING.

✓ **SIGNATURE OF PERSON RESPONSIBLE FOR CHARGES:**_____ DATE:_____

(PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

PRIMARY INSURANCE

NAME OF SUBSCRIBER_____ BIRTHDATE:_____/_____/_____

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER_____

ADDRESS OF SUBSCRIBER_____
(IF DIFFERENT THAN PATIENT)

PHONE#:(____)_____(____)_____ SSN:_____/_____/_____
HOME CELL

INSURANCE COMPANY:_____ PHONE#: (____)_____

SUBSCRIBER#:_____ GROUP#NAME:_____

SUBSCRIBER'S EMPLOYER:_____ PHONE#: (____)_____

SECONDARY INSURANCE ***IF YOU HAVE NO SECONDARY COVERAGE INITIAL HERE ____ (_____)

NAME OF SUBSCRIBER_____ BIRTHDATE:_____/_____/_____

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER_____

ADDRESS OF SUBSCRIBER_____
(IF DIFFERENT THAN PATIENT)

PHONE#:(____)_____(____)_____ SSN:_____/_____/_____
HOME CELL

INSURANCE COMPANY:_____ PHONE#: (____)_____

SUBSCRIBER#:_____ GROUP#NAME:_____

SUBSCRIBER'S EMPLOYER:_____ PHONE#: (____)_____

BRIDGEPORT PHYSICAL THERAPY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Medical History

Existing or Relevant Previous Conditions

Allergies ○ Yes ○ No

Anemia ○ Yes ○ No

Anxiety ○ Yes ○ No

Arthritis ○ Yes ○ No

Asthma ○ Yes ○ No

Autoimmune Disorder ○ Yes ○ No

Cancer ○ Yes ○ No

Cardiac Conditions ○ Yes ○ No

Cardiac Pacemaker ○ Yes ○ No

Chemical Dependency ○ Yes ○ No

Circulation Problems ○ Yes ○ No

Currently Pregnant ○ Yes ○ No

Depression ○ Yes ○ No

Diabetes ○ Yes ○ No

Dizzy Spells ○ Yes ○ No

Emphysema/Bronchitis ○ Yes ○ No

Fibromyalgia ○ Yes ○ No

Fractures ○ Yes ○ No

Gallbladder Problems ○ Yes ○ No

Headaches ○ Yes ○ No

Hearing Impairment ○ Yes ○ No

Hepatitis ○ Yes ○ No

High Cholesterol ○ Yes ○ No

High/Low Blood Pressure ○ Yes ○ No

HIV/AIDS ○ Yes ○ No

Incontinence ○ Yes ○ No

Kidney Problems ○ Yes ○ No

Metal Implants ○ Yes ○ No

MRSA ○ Yes ○ No

Multiple Sclerosis ○ Yes ○ No

Muscular Disease ○ Yes ○ No

Osteoporosis ○ Yes ○ No

Parkinsons ○ Yes ○ No

Rheumatoid Arthritis ○ Yes ○ No

Seizures ○ Yes ○ No

Smoking ○ Yes ○ No

Speech Problems ○ Yes ○ No

Strokes ○ Yes ○ No

Thyroid Disease ○ Yes ○ No

Tuberculosis ○ Yes ○ No

Vision Problems ○ Yes ○ No

Answer 'No' to all other conditions

Describe any other conditions.

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Medical Precautions

Fall History

Injury as a result of a fall in the past year? ○ Yes ○ No ○ N/A

Two or more falls in the last year? ○ Yes ○ No ○ N/A

Patient is at risk for falls? ○ Yes ○ No ○ N/A

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PATIENT NAME:____**DATE OF BIRTH:**______________

SURGICAL HISTORY

BODY REGION:________________________ SURGERY TYPE:___________________________ DATE OF SURGERY: __________________

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BODY REGION:________________________ SURGERY TYPE:___________________________ DATE OF SURGERY:__________________

BODY REGION:________________________ SURGERY TYPE:___________________________ DATE OF SURGERY:__________________

LIST OF CURRENT MEDICATIONS:

CHOOSE FROM LIST BELOW AND ENTER APPROPRIATE NUMBER ON FREQUENCY LINE:
1 AS NEEDED
2 ONCE DAILY
3 TWICE A DAY
4 THREE TIMES A DAY
5 FOUR TIMES A DAY
6 UNKNOWN

CHOOSE FROM LIST BELOW AND ENTER APPRORIATE NUMBER ON ROUTE LINE:
1 ORALLY
2 TOPICAL
3 INJECTION
4 INHALATION
5 TRANSMUCOUSAL
6 IV

DRUG:_________________________________
DOSAGE_______FREQUENCY_____ROUTE_____REASON FOR TAKING

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PATIENT NAME:_____ **DATE OF BIRTH:**_____

WAS THIS A RESULT OF AN INJURY:_____YES_____NO **IF YES:**_____WORKER'S COMP_____AUTO_____OTHER

BRIEFLY DESCRIBE YOUR CURRENT PROBLEM?:_____DATE OF ONSET:_____

DO YOU HAVE AN ATTORNEY:____ Yes _____ No ATTORNEY INFORMATION: Name:_____PHONE#: _____

HAVE YOU HAD ANY DIAGNOSTIC TESTING?: X-RAY_____CT SCAN_____MRI_____OTHER_____ DATES:_____

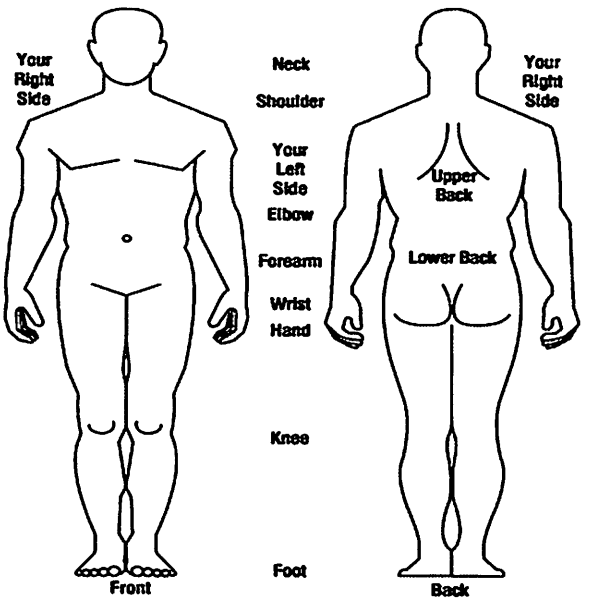
AT WHICH FACILITY WAS TESTING DONE:_____

HAVE YOU HAD ANY OTHER PHYSICAL, OCCUPATIONAL, MASSAGE, SPEECH OR CHIROPRACTIC CARE THIS YEAR?:____YES____NO
(IF YES CIRCLE THE TYPE)

(USE THE DIAGRAM BELOW TO INDICATE WHERE YOU FEEL SYMPTOMS RIGHT NOW)

USE THIS KEY TO INDICATE THE DIFFERENT TYPES OF SYMPTOMS:

PINS & NEEDLES = 000000000	BURNING = XXXXXXXXXX
STABBING PAIN=//////////////	DEEP ACHE=ZZZZZZZZZZZZ



USE THE SCALE BELOW TO RATE YOUR PAIN OVER THE PAST 24 HOURS. USE THE UPPER LINE TO DESCRIBE YOUR PAIN LEVEL RIGHT NOW. USE THE OTHER SCALES TO RATE YOUR PAIN AT ITS WORST AND BEST. RATE YOUR PAIN: 0=NO PAIN 10 =EXTREME PAIN

RIGHT NOW:	0	1	2	3	4	5	6	7	8	9	10
WORST PAIN:	0	1	2	3	4	5	6	7	8	9	10
BEST:	0	1	2	3	4	5	6	7	8	9	10

DO YOU SMOKE?: ☐ YES ____ # OF PACKS_____ # OF YEARS ☐ NO
DO YOU DRINK ALCOHOLIC BEVERAGES?: ☐ YES ☐ NO
ARE YOU PREGNANT?: ☐ YES ☐ NO

Height_____'_____"

Weight_____#

CHECK ANY OF THE FOLLOWING SYMPTOMS EXPERIENCE IN THE PAST 3 MONTHS:

☐ FEVER /SWEATS ☐ WEIGHT CHANGE ☐ NUMBNESS
☐ BOWEL/BLADDER PROBLEMS
☐ EXTREME FATIGUE ☐ TINGLING ☐ CONTINOUS PAIN
STIFFNESS ☐ HEADACHE ☐ NAUSEA/VOMITING
☐ CHANGE IN HEALTH ☐ OPEN WOUND ☐ WEAKNESS