BRIDGEPORT PHYSICAL THERAPY SERVICES, INC.

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:_____

Email Address:_____ Fax:(___)____-_____May we leave a message on answering service?____

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:(___)____-_____RelationshiptoPatient:_____

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:_____

PHYSICIAN INFORMATION

Referring Physician:_____ Date Seen_____ Next scheduled appointment_____

Office Address:_____ Phone: (____) _____-_____
Street Address City State Zip Code

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 have 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 SERVICES, INC.

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 claim. 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 responsibility 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, **if patient is under 18 years of age:** ____ ❍**Mother** ❍**Father** ❍ **Legal Guardian**

PRIMARY INSURANCE

Name of Subscriber:_____Birthdate:_____/_____/_____

Relationship to Patient: ❍Self ❍Spouse ❍ Parent ❍ Other_____

Address of Subscriber:_____
(If Different than Patient) Street Address City State Zip Code

Phone#s: (_____)_____-_____(_____)_____-_____ SS#:_____
(If Different than Patient) Home Phone Cell Phone

Insurance Co:_____ 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) Street Address City State Zip Code

Phone#s: (_____)_____-_____(_____)_____-_____ SS#:_____
(If Different than Patient) Home Phone Cell Phone

Insurance Co:_____ Phone: (_____)_____-_____

Subscriber#:_____Group#/Name:_____

Subscriber's Employer:_____Phone:(_____)_____-_____

BRIDGEPORT PHYSICAL THERAPY SERVICES, INC.

PATIENT NAME:_____DATE OF BIRTH:_____/_____/_____

MEDICAL HISTORY

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

Describe any other conditions or precautions:

Falls History

Injury as a result of a fall in the past year? ○Yes ○No Date of Fall:_____

Two or more falls in the last year? ○Yes ○No Dates of Fall:_____

PATIENT NAME:_____DATE OF BIRTH:_____/_____/_____

Surgical History

Body Region:_____ Surgery Type:_____ Date of Surgery_____

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List 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 appropriate number on Route line:
1 Orally
2 Topical
3 Injection
4 Inhalation
5 Transmucousal
6 IV

Drug:_____

Dosage_____Frequency___Route____Reason for Taking_____

Drug:_____

Dosage_____Frequency___Route____Reason for Taking_____

Drug:_____

Dosage_____Frequency___Route____Reason for Taking_____

Drug:_____

Dosage_____Frequency___Route____Reason for Taking_____

Drug:_____

Dosage_____Frequency___Route____Reason for Taking_____

Drug:_____

Dosage_____Frequency___Route____Reason for Taking_____

BRIDGEPORT PHYSICAL THERAPY SERVICES, INC.

PATIENT NAME:_____DATE OF BIRTH:_____/_____/_____

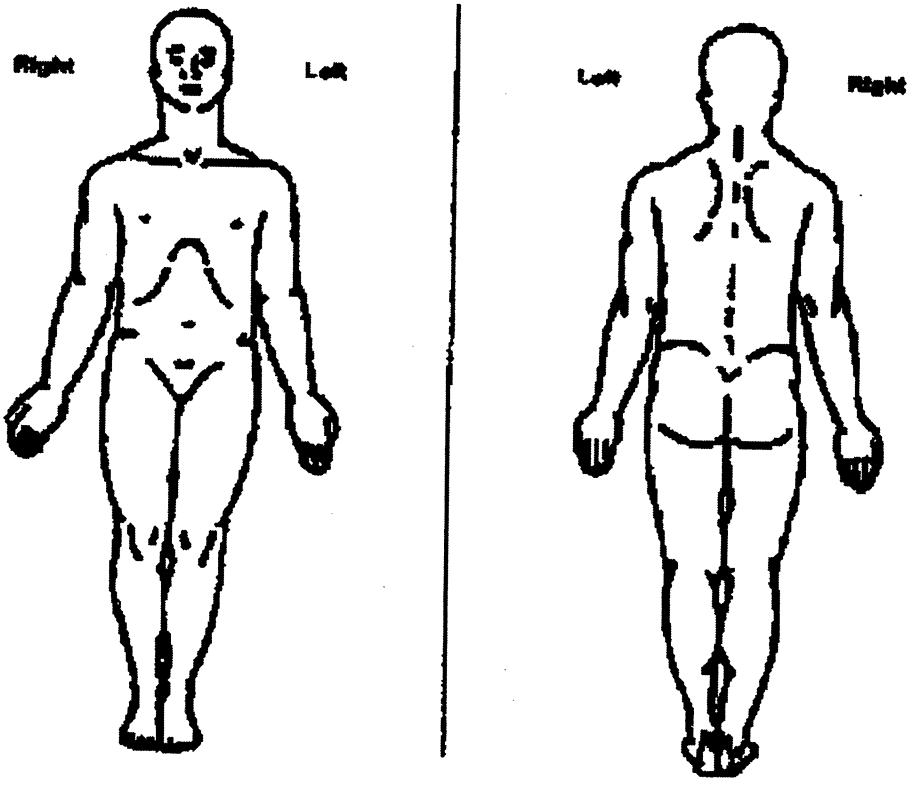
*Briefly describe your current problem:*_____ Date of Onset_____
*How did injury occur?*_____
*Claims Manager Name:*_____*Phone#:*_____
Was this injury a result of an automobile accident? ○*Yes* ○*No Attorney Info:*_____
Have you had any Diagnostic Testing? ○*X-Ray* ○*CT Scan* ○*MRI* ○*Other*_____*Dates:*_____
Have you had any other Physical, Occupation, Massage, Speech or Chiropractic Care This Year? ○*Yes* ○*No* ***If so, please 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=00000 **Burning:** xxxxxx

Stabbing Pain-/////// **Deep Ache**=zzzzzz



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**

Check any of the following symptoms experienced in the past 3 months: ❒Fever/Sweats ❒Weight Change ❒Numbness ❒Bowel/Bladder problems ❒Extreme Fatigue ❒Tingling ❒Continuous Pain ❒Stiffness ❒Headache ❒Change in Health ❒Open Wound ❒Weakness ❒Nausea/vomiting