Bristol Physical Therapy, LLC

Wellness Center - 466 East Street, Plainville, CT 06062 • Phone: 860-589-0444

www.BristolPhysicalTherapy.com • Fax: 860-314-1588

PATIENT INFORMATON

Last Name:	First:	Middle:	Mr. Ms. Miss Mrs	Date of Birth:
Cell Phone:	Work Phone:	Home Phone:		
Street Address	City	State	Zip Code	
Email:	Employer			
Primary Care Physician	City	Phone		
Referring Physician	City	Phone		

INSURANCE INFORMATION (Please give your insurance card and Driver's License to the Receptionist)

Policy Holder's Name	Date of Birth:	Phone		
Patient's Relationship to Policyholder	Self	Spouse	Child	Other
Name of Secondary Insurance (if applicable)				
Policy Holder's Name	Date of Birth:	Phone Number		
Is this a Worker's Compensation Case?	Date of Injury:	Claim Number:		
Is this a Motor Vehicle Accident?	Date of Injury:	Claim Number:		
Insurance Company Name:	Phone Number			
Do you have a lawyer involved with your case?	Name	Phone Number		

IN CASE OF EMERGENCY

Name of Local friend or relative Phone Number Work Phone Cell Phone

The above information is true to the best of my knowledge. **I authorize my insurance benefits be paid directly to Bristol Physical Therapy, LLC. I also authorize Bristol Physical Therapy, LLC to release any information required to process my claims.** I authorize Bristol Physical Therapy, LLC to bill and receive payment from any insurance company on my behalf for services rendered. **Financial Agreement:** I understand that I am responsible to provide any and all insurance information to be used for billing for physical therapy treatments. **If amounts due for treatment are not covered by insurance, I agree to be responsible for payment of all sums owed to Bristol Physical Therapy, LLC.** I understand that Bristol Physical Therapy, LLC is submitting claims to my insurance company as a courtesy to me. I agree to pay my **copays each visit.** I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and 3rd party payers to Bristol Physical Therapy, LLC. **I have read the above policies, and I agree.**

x		
	PATIENT / GUARDIAN / RESPONSIBLE PARTY	DATE

List all medications/herbs/vitamins and dosage:_____
_____
_____

List previous major injuries/surgeries: _____
_____
_____

Have you received Physical Therapy? _____ Speech Therapy? _____ Chiropractic Services? _____ # of visits _____
If yes, please let staff, receptionist or P. T. know how many treatments you have received. _____
What other treatments are you receiving and by whom? (acupuncture, massage, naturopathic, injections)
_____
Part of body being treated? _____
When did injury occur or onset of complaint?_____
How did it happen? (i.e., trauma, woke up with it, arthritis, post surgical pain, etc.) _____
_____
_____
What makes it worse? _____
What makes it better? _____
Do you smoke? _____ Use Alcohol? _____ Is there anything else I need to know about?_____
_____
Are you allergic to any medications? _____

Please indicate any medical problems or conditions that pertain to you.

Cancer	Recent Injuries (whiplash, sprain, deep bruise)
Headaches (migraines, PMS, tension, cluster, other)	Circulatory Condition (heart disease, varicose veins, phlebitis, arrhythmia's, arteriosclerosis, other)
Osteoarthritis	Neurological Condition (sciatica, numbness/tingling, stroke, epilepsy, other)
High Blood Pressure	Joint problems, pain or stiffness (arthritis, gout, hypermobile joints, sacroiliac problems, other)
Skin Condition (allergies, skin cancer)	Bone Conditions (Osteoporosis, previous fracture, cancer, other)
Diabetes	Lymphatic Condition (swollen glands, lymphoma, lymphedema, other)
Pregnancy	Emotional Difficulties (depression, anxiety, psychotic episodes, Stress, other)
Rheumatoid Arthritis	Other

Please give more detailed information if you have checked any of the above medical problems or conditions.
_____
_____
_____
_____
_____
_____