Bristol Physical Therapy, LLC

400 Middle St, Bristol, CT 06010/ Phone: 860-589-0444/ FAX: 860-314-1588

www.BristolPhysicalTherapyLLC.com

PATIENT INFORMATION					
Patient's Last Name	First	Middle	Mr Mrs	Miss Ms	Marital Status Date of Birth
Home Phone	Work Phone		Cell Phone		
( )	( )		( )		
Street Address	City		State		ZIP Code
Email	Employer		Social Security Number		
Primary Care Physician	City	Phone Number		Next Dr Appointment	
		( )			
Referring Physician, City		Phone Number		Next Dr Appointment	
		( )			

INSURANCE INFORMATION (Please give your insurance card and driver's licence to the receptionist)				
Policy Holder's Name	Date of Birth	Social Security Number	Home Phone No.	
			( )	
Patient's Relationship to Policy Holder	☐ Self	☐ Spouse	☐ Child	☐ Other
Name of Secondary Insurance (if applicable)				
Policy Holder's Name	Date of Birth	Social Security Number	Home Phone No.	
			( )	
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 No: ( )		
Other treatments received?	Chiropractic?	Massage?	Acupuncture?	Physical Therapy?
Do you have a lawyer involved with your case?	Name:	Phone No: ( )		

IN CASE OF EMERGENCY			
Name of Local friend or relative	Home Phone	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? _____ Do you have anything I need to know about?
Are you allergic to any medications? _____
Please indicate any medical problems or conditions that pertain to you.

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

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

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