Name: _____ Date:_____

1. MEDICAL HISTORY:

Do you have high blood pressure?.....	Yes	No
Do you have heart disease?.....	Yes	No
Do you experience angina (chest pain)?.....	Yes	No
Do you experience shortness of breath?.....	Yes	No
Do you have lung disease?.....	Yes	No
Do you experience heartburn or upset stomach?.....	Yes	No
Have you experienced recent weight loss/gain?……	Yes	No
Do you have a thyroid condition?……	Yes	No
Do you have diabetes?……	Yes	No
Do you have low blood sugar?.....	Yes	No
Do you have a history of cancer?.....	Yes	No
Do you have osteoporosis?.....	Yes	No
Do you have unusual joint pain and/or swelling?……..	Yes	No
Do you have a history of fractures?.....	Yes	No
Do you have any metal implants?.....	Yes	No
Do you have a pacemaker?.....	Yes	No
Do you have impaired hearing?.....	Yes	No
Do you have impaired vision?.....	Yes	No
Have you experienced an increase in frequency or intensity of headaches?	Yes	No

Current Height: _____ ft _____ in Weight: _____ lbs

2. ANY OTHER MEDICAL PROBLEMS? _____

_____

_____

3. Are you now or do you have any reason to believe you may be pregnant? Yes No

4. PLEASE LIST ALL MEDICATIONS AND PURPOSES: _____

_____

_____

_____

5. PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES: _____

_____

_____

_____

_____

6. PLEASE LIST ALL DIAGNOSTIC TESTS FOR YOUR CURRENT PROBLEMS: _____

_____

_____

_____

7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEMS: _____

_____

_____

We appreciate your completion of this questionnaire as it helps your therapist get a better understanding of your total health status. The questionnaire is a part of your confidential medical record and your therapist will answer any of your questions during your examination.

_____ _____

Signature Date

CASCO BAY PHYSICAL THERAPY

Patient Information Form

Date: _____

Please print:

Name: _____ Referring Physician: _____
(Last) (First) (M)

Address: _____ Primary Care Physician: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Cell Phone: _____

Place of Employment: _____Alternate Phone: _____

E–Mail Address: _____ Gender: _____

In case of emergency contact: _____ Phone: _____

Reason for Referral: _____

Date of injury/onset: _____

Date of Surgery: _____

Work Related: Yes No Auto Accident: Yes No Other Accident: Yes No

Patient's Primary Insurance: _____ Policy No: _____
(Insurance Company Name)

Patient's Secondary Insurance: _____ Policy No: _____
(Insurance Company Name)

Have you been a patient of Casco Bay Physical Therapy before? Yes No

Are you presently receiving Home Health services such as nursing, IV therapy, etc? Yes No

Have you received speech therapy or physical therapy this year ? Yes No

How did you hear about us? ❒ Doctor Recommended ❒ Family/Friend ❒ Website

❒ Phonebook ❒ Other: _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I understand fully that, in the event that my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I hereby assign payment directly to Casco Bay Physical Therapy benefits due to me for services rendered. I understand I am financially responsible for any balance remaining after payment of benefits according to my insurance policy.

THIRD PARTY LIABILITY POLICY:
This office does not accept third party liability insurance payments, such as motor vehicle or personal injury accidents.

SUPPLIES:
I understand that I am financially responsible for all and any supplies that are given to me during the course of my treatment. Payment will be due on the day the supply is received.

MEDICARE PATIENTS:
I have been notified by Casco Bay Physical Therapy that Medicare only covers 80% of all approved charges after which I am personally and fully responsible for the remaining percentage co-payment along with my annual deductible (if it has not been met). As well, I have been informed that Medicare has enforced a soft cap of $2110.00 per year for physical therapy and speech therapy combined, after which I would be responsible for payment of services. Most secondary insurances will not continue to pay for services denied by Medicare.

CANCELLATIONS:
Please call 24 hours in advance to cancel your scheduled appointment; otherwise there will be a $50.00 fee to be paid at your next appointment. Thank you for your understanding and attention to cancelling any appointment you cannot attend.

Patient's initials: 

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I, _____, have received the **Notice of Privacy Practices** from Casco Bay Physical Therapy.

Patient Signature: _____ Date: _____