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. OB/GYN:

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? _____
_____
_____

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your total health status. We appreciate your completion of this questionnaire and your therapist will answer any of your questions during your examination. The questionnaire is considered a part of your confidential medical record.

_____ _____
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: _____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

E–Mail Address: _____ Cell Phone: _____

How would you like us to communicate with you? (Check all that apply). *We will only email you appointment reminders, home exercise programs and/or a quarterly newsletter.
❒ Home phone ❒ Cell phone ❒ Work phone ❒ Email*

Gender: M F 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 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 cap of $2010.00 per year for physical therapy and speech therapy combined, after which I would be responsible for payment of services. Most medigap 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**. This notice is dated _____.

Patient Signature: _____ Date: _____