PATIENT REGISTRATION
PLEASE PRINT & COMPLETE ALL PORTIONS

Today's Date Mo. _____ **Day** _____ **Year**_____

PART OF BODY TO BE TREATED: _____ **REFERRING DOCTOR:** _____

Did you have surgery: ☐ Yes ☐ No Surgery Date: _____

Do you have a referral: ☐ Yes ☐ No ☐ Dr. Will Fax ☐ We have Referral Have you been here before: ☐ Yes ☐ No

PATIENT'S NAME: _____ SEX: _____ DATE OF BIRTH: _____

EMAIL _____

MAILING ADDRESS: _____ HOME TELEPHONE _____
Street or Box Number City State Zip

SOCIAL SECURITY #: _____ CELL PHONE _____

MARITAL STATUS: (check one) ☐ Married ☐ Single ☐ Divorced ☐ Other _____

PATIENT'S EMPLOYER: _____ WORK TELEPHONE _____

PRIMARY INSURANCE _____ I.D NO. _____ Group NO. _____

SECONDARY INSURANCE _____ I.D. NO. _____ Group NO. _____

SUBCRIBER'S/POLICY HOLDER'S NAME IF DIFFERENT FROM PATIENT'S ABOVE: _____

DATE OF BIRTH: _____ EMPLOYER: _____

SUBSCRIBER/POLICY HOLDER'S ADDRESS IF DIFFERENT FROM PATIENT'S ABOVE:

_____ PHONE: _____
Street or Box Number City State Zip

If Medicare is Primary are you receiving Home healthcare: ☐ Yes ☐ No **If yes, what is your discharge:** _____

IS THIS A WORK RELATED INJURY: ☐ Yes ☐ No **If yes, complete the following:**

WORKER'S COMPENSATION INSURANCE CARRIER: _____

EMPLOYER AT TIME OF INJURY: _____

DATE OF INJURY: _____ Claim No: _____

Adjuster Name: _____ Phone No. _____ Fax No. _____

Do you have an attorney: ☐ Yes ☐ No Attorney's Name: _____ Phone No. _____

IS THIS A MOTOR VEHICLE RELATED INJURY: ☐ Yes ☐ No **If yes, complete the following:**

DATE OF INJURY: _____ **DO YOU HAVE MEDPAY (automobile insurance medical benefits):** ☐ Yes ☐ No

In what state did the accident happen: _____

Auto Insurance Claim No: _____ Auto Insurance Name _____

Contact person's name _____ Phone No. _____

Do you have an attorney: ☐ Yes ☐ No Attorney's Name: _____ Phone No. _____

IN CASE OF EMERGENCY CONTACT: _____ Relationship _____

Telephone: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS I hereby give authorization for payment of insurance benefits to be made directly to Thomaston Physical Therapy, LLC. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.Patient/Legally Authorized Representative Signature:

Signature: _____ Date: _____

THOMASTON PHYSICAL THERAPY, LLC

MEDICAL HISTORY FORM

NAME: _____

MEDICAL DOCTOR: _____

LAST MEDICAL EXAM: _____

HEIGHT: _____ WEIGHT: _____

ALLERGIES: _____

_____

CURRENT MEDICATIONS: _____

_____

CHECK THOSE CONDITIONS THAT APPLY TO YOU:

[ ] HEART DISEASE

[ ] RESPIRATORY DISEASE

[ ] DIABETES: TAKING INSULIN? YES NO

[ ] SEIZURE DISORDER: DATE OF LAST SEIZURE: _____

[ ] CVA (CEREBROVASCULAR ACCIDENT OR STROKE) DATE: _____

[ ] INFECTIOUS DISEASE: EXPLAIN: _____

_____

[ ] CURRENT PREGNANCY: DUE DATE: _____

[ ] DEPRESSION

[ ] ALCOHOL ABUSE HISTORY

[ ] DRUG ABUSE HISTORY

[ ] SMOKER: HOW MUCH: _____ HOW MANY YEARS: _____

[ ] CANCER: WHAT TYPE: _____

[ ] RECENT SURGERIES DATE: _____ TYPE: _____

[ ] OTHER: _____

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN: _____ DATE: _____

CC:

THOMASTON PHYSICAL THERAPY, LLC
10 MARINE STREET
THOMASTON, CT 06787
PHONE (860)-283-2316
FAX (860)-283-6079

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read and/or received a copy of Thomaston Physical Therapy, LLC's notice of privacy practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request any amended Notice of Privacy Practices at each appointment.

_____

Signature Date

_____

Parent/Guardian Date

_____

I,_____, authorize the following person or person's to be given my health information if requested:

Name_____ Relationship._____

Phone No._____

Name_____ Relationship_____

Phone No._____

Name_____ Relationship._____

Phone No._____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign
[ ] Communication barriers prohibited obtaining acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other (Please Specify)

_____

_____