



# PATIENT INFORMATION

563 Madison Ave. N., Bainbridge Island, WA 98110 (206)855-8455

Date: \_\_\_\_\_

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Gender:  F  M

DOB: \_\_\_\_\_ Marital Status:  Single  Married  Other Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone:  Home \_\_\_\_\_  Cell \_\_\_\_\_  Work \_\_\_\_\_  
(Please check where we can leave a detailed message of patient information during business hours)

Email Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Workman's Compensation or No Fault Primary M.D. \_\_\_\_\_  
Seeking treatment for a condition related Referring M.D.: \_\_\_\_\_  
to a work or auto injury?  Yes  No

**Workman's Compensation or Motor Vehicle Accident**

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Claims Manager: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Conditions of Treatment & Financial Policy**

**PATIENT RESPONSIBILITY:** As a patient receiving medical care, I am aware of my insurance coverage and limitations. It is my responsibility to determine insurance benefits and provide Bainbridge Island Physical Therapy with correct billing information. I will assist with obtaining necessary pre-authorizations when needed as failure to obtain this may result in a reduction or rejection of benefits by the insurance company. I will be responsible for any deductible, copayments, or other patient balances due and payable upon receipt of a monthly statement. Payment options include cash, check or HSA credit card. I understand that past due accounts may be assigned to an outside agency for collection. I have had an opportunity to ask questions and accept the responsibility of these terms.

**CONFIDENTIALITY/RELEASE OF MEDICAL INFO:** Your medical history and personal information will be held in strict confidence. Your case will only be discussed or shared for purposes of necessary communication with your physician or to satisfy requirements for payment. A detailed copy of our Privacy Policy is available upon request.

**ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL INFO:** I hereby authorize payment of medical benefits to Bainbridge Island Physical Therapy for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I certify that the information I provide is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.

**NO SHOW/CANCELLATION POLICY:** Bainbridge Island Physical Therapy reserves the right to charge a \$45 fee for patients who do not show up to a scheduled appointment or cancel less than 4 hours in advance. This fee will not be billed to or covered by your insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Bainbridge Island Physical Therapy HEALTH HISTORY FORM

Please speak directly with your Physical Therapist if you have any medical history issues that you wish not to list.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Date of last complete medical examination: \_\_\_\_\_ Performed by: \_\_\_\_\_

Are you currently receiving ANY form of Home Health Care?  Yes  No For? \_\_\_\_\_

Next scheduled Dr. appointment(s) Date: \_\_\_\_\_ Physician: \_\_\_\_\_

When did your condition start: Give specific date of injury or onset of pain? \_\_\_\_\_

Did you have surgery?  Yes  No Surgery Date: \_\_\_\_\_ Procedure: \_\_\_\_\_

Did you have the following tests?  XRay  MRI  CT Scan  EMG Other: \_\_\_\_\_

Have you been treated here or by another physical therapist before?  Yes  No Same condition?  Yes  No

Where? \_\_\_\_\_ When? \_\_\_\_\_ Who referred you to BIPT? \_\_\_\_\_

Are you currently taking any medications?  Yes  No Please list below or bring in a medication list.

Do you have Pain? If so draw on the Body Chart where your pain is located

What does your pain feel like? (check all that apply)

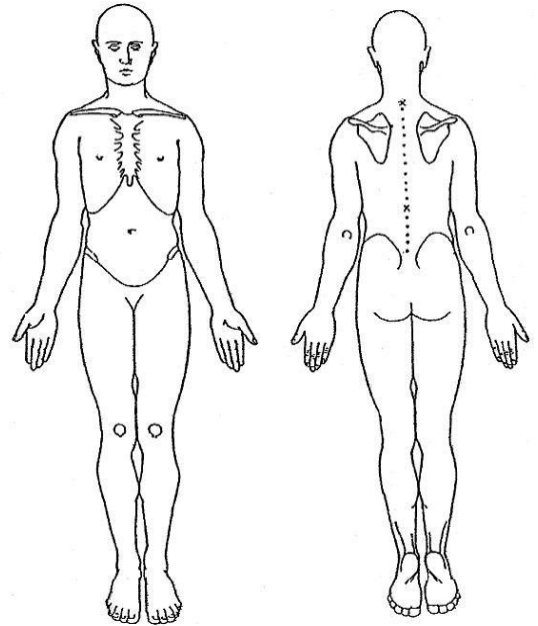
- Sharp  Burning  Aching  Tingling  Numbness

Other \_\_\_\_\_

Does pain radiate to arms or legs?  Yes  No

Does the pain keep you up at night?  Yes  No

Rate your PAIN: \_\_\_\_\_ (0=none, 10=severe)



What makes your pain worse? (check all that apply)

- Lying Down  Sitting  Standing  Walking Other \_\_\_\_\_

What eases your pain? (check all that apply)

- Lying Down  Sitting  Standing  Walking Other \_\_\_\_\_

Recent weight loss or gain?  Yes  No Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

Exercise when injury free?  Yes  No Any other conditions we should be aware of? \_\_\_\_\_

Are you pregnant?  Yes  No

Were you in a Motor Vehicle Accident?  Yes  No

Do you now or have had any of the following? (check all that apply)

- Heart Disease  Diabetes  Allergies  High Blood Pressure  Asthma
- Heart Attack  Pacemaker  Kidney Problems  Headaches  Thyroid Issues
- Cancer  Infectious Disease  Hernia (any)  Nervous Disorders  Seizures
- Stroke  Dizziness  Shortness of Breath  Previous Surgery  Metal Implants

If yes to any of the above please give details and approximate dates: \_\_\_\_\_

All statements above are true to the best of my knowledge \_\_\_\_\_

PATIENT SIGNATURE and DATE