livefit

Greater Hartford Physical Therapy, P.C. **Select Orthopedics, LLC.**

PATIENT INFORMATION

Mr. Mrs. Ms.: _____ Gender: □Male □Female
(Circle One) First Name Middle Initial Last Name
Address: _____ Apt/Floor: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Marital Status: □Married □Single □Other
Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Primary Care Physician: _____ Email Address: _____
Would you like to receive appointment reminders via Text or Email? □Yes □No If yes, please select one: □Text □Email
Cell Phone Carrier: □AT&T □Boost Mobile □Metro PCS □Sprint □T-Mobile □Verizon □Other: _____
Employer Name and Address: _____
Emergency Contact Name: _____ Phone Number (_____)_____-_____
How did you hear about our Practice? _____

Person responsible for bill (Spouse/Parent/Attorney information):
Name: _____ Phone Number: (_____)_____-_____
Address: _____
Street City State Zip Code
Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____
Relationship to Patient: □Spouse □Parent/Guardian □Attorney

Primary Insurance Information:
Plan Name:_____ I.D. Number: _____
Policy Holder: _____ Policy Holder's Date of Birth: ____/____/_____
Policy Holder's Social Security Number: _____-_____-_____
Secondary Insurance Information:
Plan Name: _____ I.D. Number: _____
Policy Holder: _____ Policy Holder's Date of Birth: _____/_____/_____
Policy Holder's Social Security Number: _____-_____-_____

If Due to Worker's Comp Injury:
Insurance Company Name: _____ Date of Injury: _____/_____/_____
Address: _____ Claim Number: _____
Adjuster's Name: _____ Phone Number: (_____)_____-_____

If Due to Motor Vehicle Accident:
Auto Insurance Name: _____ Date of Accident: ____/____/_____
Policy Number: _____ Claim Number: _____
Auto Make: _____ Model: _____ Year: _____
Were you the driver or passenger? _____ State where accident occurred? _____

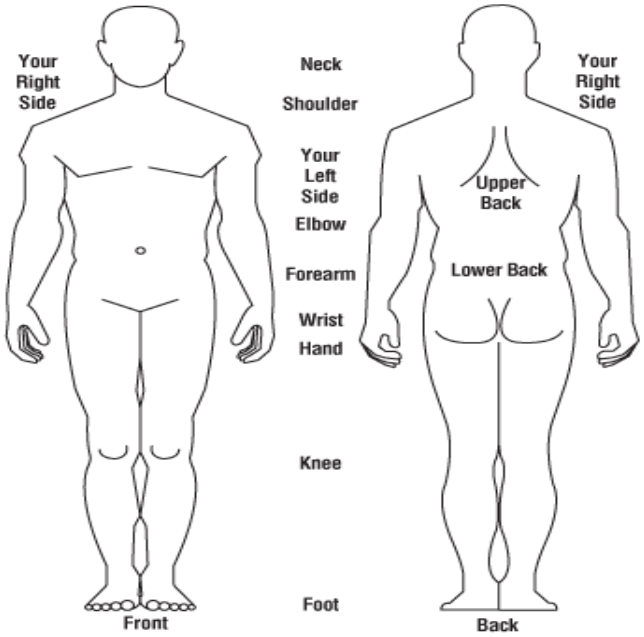
I, the undersigned, do hereby authorize treatment of myself. I authorize the responsible insurance company to directly pay medical benefits to this facility for services rendered to myself. I authorize my attorney and responsible insurance company to pay any outstanding balance due on my account from any and all proceeds that arise from settlement of any litigation, either pending or final, that was initiated and settled due to the injuries that were evaluated and treated. I further agree to be responsible for payment of services and in the event of non-payment by any third party insurance company, attorney, or other; I will be responsible for payment of services as well as reasonable collection fees. I also authorize the release of any medical information necessary to process my claim.

Patient/Guardian Signature _____ Date: _____

MEDICAL HISTORY

Name: _____

Please mark on the diagram below the areas where you feel your symptoms:



1. What body areas did you injure? _____
2. How did this injury occur, if due to an accident? _____
3. Did this accident occur on work time? □Yes □No
4. Did you go to the Emergency Room for this accident/illness? □Yes □No
   If yes, where? _____ Were x-rays done? □Yes □No
5. Have you had any prior accidents? □Yes □No If yes, when? _____
6. Have you seen any other physicians for this accident/illness? □Yes □No
   If yes, where? _____ Physician's name: _____
7. Are you taking any medications for this injury/illness? □Yes □No
   If yes, please list: _____
8. Are you taking any medications for any other reasons? □Yes □No
   If yes, please list: _____
9. Have you had any surgeries? □Yes □No
   If yes, please list: _____
10. Do you have or have you had any other health conditions? □Yes □No
    If yes, please list: _____
11. Do you have any allergies? □Yes □No If yes, please list: _____
12. Do you have any metal in your body? □Yes □No If yes, where? _____
13. Do you have a pacemaker? □Yes □No
14. Are you pregnant? □Yes □No If yes, how many weeks? _____
15. Are you currently receiving any physical therapy or chiropractic treatments anywhere else? □Yes □No
    If yes, where? _____

Patient/Guardian Signature: _____ Date: _____