

DATE _____

NEW PATIENT INFORMATION

NAME: _____

BIRTHDATE: _____

SSN: _____

MALE FEMALE

ADDRESS: _____

MAILING ADDRESS: _____

(IF DIFFERENT FROM ABOVE)

OCCUPATION: _____

HOME TELEPHONE: _____

WORK TELEPHONE: _____

E-MAIL _____

CELLPHONE: _____

NAME OF RESPONSIBILITY PARTY IF PATIENT IS A MINOR: _____

NAME AND ADDRESS OF HEALTH INSURANCE: _____

NAME OF POLICYHOLDER/SUBSCRIBER: _____

SUBSCRIBER BIRTHDATE: _____

SUBSCRIBER SSN: _____

SUBSCRIBER RELATIONSHIP TO PATIENT:

SELF SPOUSE PARENT

REFERRING

PHYSICIAN: _____

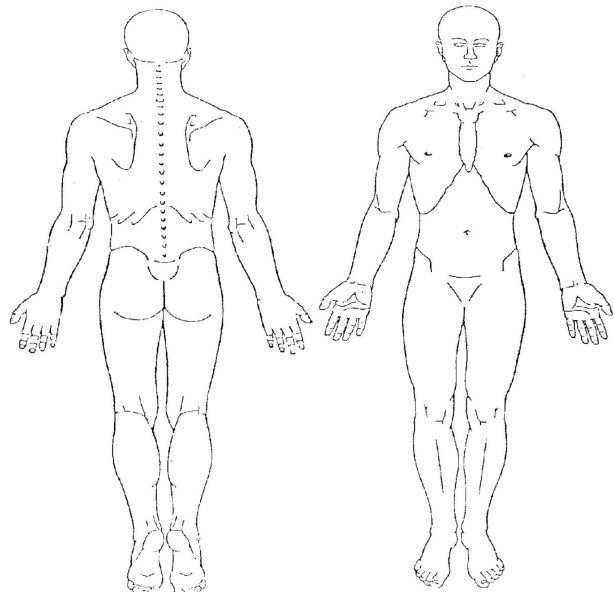
PRIMARY CARE PHYSICIAN NAME AND TELEPHONE: _____

EMERGENCY CONTACT NAME AND TELEPHONE: _____

WHERE DID YOU HEAR ABOUT US?

Show us where you hurt. Please mark with X's the area(s) to show your pain.

- My doctor
- Friend
- Sun Journal
- Bridgton News
- Advertiser Democrat
- Magic Lantern
- Gift Certificate
- Other: _____



FOR RBPT USE ONLY

Rx Date: _____

Visit Limit: _____

Ins Verified By: _____

MEDICAL INFORMATION

Do you have a medical history of any of the following? (Please circle)

Seizures Diabetes Fractures Cancer
Heart Problems Hepatitis Pregnancy Other _____

Do you: (Please circle YES or NO)

1) Smoke Y N _____ packs/day 3) Exercise regularly Y N

2) Use alcohol Y N _____ drinks/day 4) Have an allergy to latex Y N

SURGICAL PROCEDURES: _____

PLEASE LIST ALL MEDICATIONS: _____

REASON FOR TODAY'S VISIT: _____

By signing below, I GIVE MY CONSENT TO BE TREATED BY RICHARD BADER PHYSICAL THERAPY. Further, I authorize the release of payment benefit to RBPT and/or medical information to/from physician, insurance company, legal counsel and/or other agents. I further acknowledge that I am responsible for all payments incurred through my treatment, and RBPT has the right to collect all money due. I agree to pay my co-pay at the time of treatment. I give my consent for RBPT to contact me at work or at home as needed. I acknowledge that a copy of the Notice of Privacy Practices as per HIPPA requirements is available to me in the waiting room.

SIGNATURE (Parent if patient is a minor): _____ DATE: _____

CANCELLATION / NO SHOW POLICY

Our cancellation/no show policy is designed to improve the quality of care for our present patients and allow us to see new patients who need our services. Any combination of three cancellations and/or no shows will result in Discharge from Physical Therapy. Your physician will be contacted to inform him of the reason for Discharge.

Providing the highest possible quality of care for patients is our greatest priority

About our Logo



The 35th hexagram in the I-Ching represents the sun rising above the earth, predicting easy progress in the natural order of life. Bader Physical Therapy is committed to assisting our patients in experiencing this progression on their road towards health.

POLAND
NORWAY
BRIDGTON

Richard Bader Physical Therapy

Phone: (207) 998-5493

Phone: (207) 743-5493

Phone: (207) 647-5493