



PLYMOUTH BAY ORTHOPEDIC & SPORTS THERAPY
95 Tremont Street, Suite 20, Duxbury, MA 02332
(PH) 781-934-7292

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security # _____ DOB _____ Age _____ M / F

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____

Emergency Contact _____ Relationship _____ Phone # () _____

Are you a full time student? _____

GUARANTOR INFORMATION (if under 18 or Full Time Student)

Last Name _____ First Name _____

Social Security # _____ DOB _____ Relationship: Spouse/Dependent/Guard

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____

HAVE YOU HAD THERAPY THIS YEAR? _____ **When?** _____

Are you currently receiving ANY home services at this time? _____ **DISCHARGE DATE** _____

Referring Physician _____ Phone () _____

Primary Care Physician _____ Phone () _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____

Subscriber Name _____ Subscriber D.O.B. (required) _____

Relationship to Patient: Self / Spouse / Dependent

Secondary Insurance _____ ID# _____

Subscriber Name _____ Subscriber DOB (required) _____

Relationship to Patient: Self / Spouse / Dependent

Is this a workers' compensation accident? _____ **Date of Injury** _____

Is this a motor vehicle accident? _____ **Date of Injury** _____

Patient/Parent/Guardian Signature

Date



PLYMOUTH BAY ORTHOPEDIC & SPORTS THERAPY

OTHER INSURANCE INFORMATION

PATIENT NAME _____ DOB _____

WORKERS' COMPENSATION INFORMATION

NAME OF EMPLOYER _____

EMPLOYER PHONE NUMBER () _____ - _____

CLAIM # _____ DOI: _____

ADJUSTER NAME _____

Adjuster Ph () _____ - _____ Adjuster Fax () _____ - _____

INSURANCE CO. TO BE BILLED

NAME _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MOTOR VEHICLE ACCIDENT INFORMATION

CLAIM # _____ DOA: _____

ADJUSTER NAME _____

Adjuster Ph () _____ - _____ Adjuster Fax () _____ - _____

INSURANCE CO. TO BE BILLED

NAME _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____



PLYMOUTH BAY ORTHOPEDIC & SPORTS THERAPY

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Problem we are seeing you for today _____

Date of Onset (required) _____

How did this occur? _____

Previous Treatment for this problem? _____ Date of treatment: _____

Next appointment with your physician? _____

Please indicate if you have had any of the following:

- ___ Allergies ___ Emphysema ___ Memory Loss
___ Anemia ___ Fevers ___ Neck or Back Problems
___ Arthritis/Joint Pain ___ Fractures/Broken Bones ___ Osteoporosis
___ Asthma ___ Gout ___ Rashes
___ Blurred Vision ___ Headaches ___ Seizures
___ Breathing Problems ___ Hearing Loss ___ Stroke/CVA
___ Cancer, Type ___ Heart Disease/Attack ___ Swelling of Arms/Legs
___ Chest Pain ___ Hepatitis ___ Thyroid Disease
___ Clotting/Bleeding Problems ___ High Blood Pressure ___ Tuberculosis
___ Depression ___ High Cholesterol ___ Ulcers/Reflux
___ Diabetes ___ HYT Disease ___ Unplanned Weight Loss
___ Dizziness/Fainting ___ Kidney/Urinary Problems ___ Lyme Disease
___ DVT/Blood Clots/Phlebitis -- Other

List all operations you have had with an approximate date:

- 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please List any medications you are taking:

- 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Patient/Guardian Signature

Date



Patient Name: _____

PATIENT RESPONSIBILITIES – PLEASE READ AND SIGN

- **Referrals/Prior Approvals (if applicable):** I understand my insurance company will not reimburse for the cost of today’s services without a referral/prior approval and I am responsible for payment of the office visit charge or any other charges I may incur.
- **Co-pay (if applicable):** I understand that co-pay amounts are part of the agreement that I have with my insurance company and are due at the time of each visit and that I am responsible for that payment.
- **Deductible (if applicable):** I understand that I have a calendar year deductible for outpatient therapy as outlined in my insurance policy. I understand that I am responsible for any balance that my insurance company does not cover but has been applied to my deductible.
- **Co-Insurance (if applicable):** I understand that I have a co-insurance responsibility as outlined in my insurance policy and that I am responsible for any co-insurance balance as set forth by my insurance company.
- **Authorization to pay benefits to the provider:** I hereby authorize payment directly to the provider for medical benefits otherwise payable to me for services as described, realizing that I am responsible to pay for non-covered services.
- **Workers’ Compensation Information (if applicable):** I understand that it is my responsibility to provide all workers’ compensation billing information at the time of the initial visit. I realize that without this information, I will be responsible for any charges incurred at the time of the visit. I understand that my health insurance information will be provided and benefits will be utilized in the event that my workers’ compensation claim is denied.
- **Motor Vehicle Information (if applicable):** I understand that it is my responsibility to provide all claim information associated with my motor vehicle accident at the time of the initial visit. I realized that without this information, I am responsible for any charges incurred at the time of the visit. I understand that my health insurance information will be provided and benefits will be utilized in the even that my PIP is exhausted.
- **Cancellations/No Shows:** In order to give all our patients the time and care they need for each treatment, we must follow the schedule. Please be on time for all appointments, and call ahead if you need to cancel an appointment. Consistent lateness and/or missed appointments will result in cancellation of treatment.

Please notify us of any changes with your insurance status during treatment. Thank you.

I have read and understand all of the preceding information and certify the information provided is true and correct to the best of my knowledge.

Signature

Date

Parent/Guardian Signature

Date

Initial: _____ Date: _____
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