SWANNER PHYSICAL THERAPY

NEW PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____

Address _____ Social Security No. _____

City, State, Zip _____ Home Phone _____

Driver's License # _____ Name of Spouse _____

Marital Status (circle one): Single Married Divorced Widowed Sex (circle one): M F

Referring Physician _____ Phone _____

Employer _____ Work Phone _____

Address _____ Occupation _____

City, State, Zip _____ Full time _____ Part time _____

Student? Yes ____ No ____ If yes, please check one: Full time _____ Part time _____

If student, name of responsible party/parent _____

Is this a personal injury or motor vehicle accident? Yes ____ No ____ If yes, date of injury _____

Is your injury work-related? Yes ____ No ____ If yes, date of injury _____

Do you have an attorney involved in this case? Yes ____ No ___

If yes, please provide: Name _____ Phone _____

Street Address _____ City, State, Zip _____

Insurance Information: (Circle One) Worker's Comp. Medicare Pvt. Insurance Cash Lien

Insurance Carrier _____ Policy No. _____

Street Address _____ Group No. _____

City, State, Zip _____ Claim No. _____

Contact Person/Adjuster _____ Phone _____

I authorize payment of medical benefits to "Swanner Physical therapy" as indicated on the itemized bill. I authorize Swanner Physical Therapy to release medical and billing information required to process claims for payment or as necessary for care in the course of my therapy. I understand that Swanner Physical Therapy is billing my insurance as a courtesy, and that I am ultimately responsible for the charges.

Signed _____ Date _____

1202 Maricopa Highway, Suite B ▪ Ojai, California 93023 ▪ 805 646 6313 ▪ fax 805 646 6318

SWANNER PHYSICAL THERAPY

CURRENT AND PAST MEDICAL HISTORY

AS FAR AS *YOU* ARE CONCERNED, WHAT IS YOUR MAIN PROBLEM?

_____

_____

WHEN DID IT START? _____

DID YOU HAVE SURGERY FOR THIS PROBLEM _____ WHEN? _____

HAVE YOU EVER HAD X-RAYS, MRI OR SPECIAL TESTING? _____

IF SO, WHAT WERE THE RESULTS OF THIS TESTING? _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD:

DIABETES?	YES ___	NO ___
HIGH BLOOD PRESSURE?	YES ___	NO ___
HEART PROBLEMS OR HEART DISEASE?	YES ___	NO ___
PACEMAKER?	YES ___	NO ___
PRIOR SURGERIES?	YES ___	NO ___
SEIZURES?	YES ___	NO ___
METAL IMPLANTS?	YES ___	NO ___
ALLERGIES?	YES ___	NO ___
A STROKE?	YES ___	NO ___
CANCER?	YES ___	NO ___

PLEASE EXPLAIN ANY "YES" ANSWERS _____

_____

_____

ARE YOU PREGNANT?	YES ___	NO ___
ARE YOU CURRENTLY WORKING?	YES ___	NO ___

IF NOT, IS IT BECAUSE OF YOUR INJURY? _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO "SWANNER PHYSICAL THERAPY" AS INDICATED ON THE ITEMIZED BILL. I AUTHORIZE SWANNER PHYSICAL THERAPY TO RELEASE MEDICAL AND BILLING INFORMATION REQUIRED TO PROCESS CLAIMS FOR PAYMENT OR AS NECESSARY FOR CARE, IN THE COURSE OF MY TREATMENT.

SIGNED _____ DATE _____

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SWANNER PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS / CONSENT TO TREATMENT

PATIENT RESPONSIBILITY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I,_____, hereby assign all medical benefits to which I am entitled to Swanner Physical Therapy in the event they file insurance on my behalf.
I understand that I am financially responsible for all charges whether or not paid by said insurance.
I hereby authorize Swanner Physical Therapy to release all information necessary to secure the payment of said benefits. A copy of this agreement shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Swanner Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

_____ _____

Patient's Signature Date

NOTICE OF NONDISCRIMINATION

Pursuant to TITLE IV of the Civil Right Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, Swanner Physical Therapy does not discriminate in the provision of services on the basis of race, color, national origin, disability or age.

_____

Patient's Initial

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