SWANNER PHYSICAL THERAPY
1202 Maricopa Hwy., Suite B • Ojai, California 93023
805 646 6313 • Fax 805 646 6318

NEW PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Age:_____

Address:_____ Social Security Number:_____

City, State, Zip:_____ Home Phone:_____

Cell Phone:_____ Work Phone: _____

Email:_____

Preferred method of communication: Text _____ Email _____ Phone _____

Primary Care Physician:_____

Employer:_____ Occupation:_____

Address:_____ City, State, Zip: _____

Are you a student? Yes _____ No _____ School:_____

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

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

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

If yes, please provide: Name _____ Phone Number _____

Street Address: _____ City, State, Zip: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

I authorize payment of medical benefits to "Swanner Physical Therapy" as indicated on the itemized bill. I authorize Swanner Physical Therapy to release medical 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.

Signature _____ **Date** _____

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Name: _____ Email: _____

CURRENT AND PAST MEDICAL HISTORY

AS FAR AS YOU ARE CONCERNED, WHAT BRINGS YOU INTO PHYSICAL THERAPY? _____

_____

WHEN DID IT START? _____

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? _____

DID YOU HAVE SURGERY FOR THIS PROBLEM? _____ WHEN? _____

RESULTS OF X-RAYS, MRI OR SPECIAL TESTING _____

CURRENT MEDICATIONS: (NONE ____): _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD:		EXPLAIN:
DIZZINESS OR VERTIGO?	YES _____ NO _____	_____
RHEUMATOID ARTHRITIS?	YES _____ NO _____	_____
NEUROLOGICAL DISORDER?	YES _____ NO _____	_____
DIABETES?	TYPE I _____ TYPE II_____ 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 _____	_____
OSTEOPOROSIS?	YES _____ NO _____	_____

HOW IS YOUR OVERALL HEALTH? GOOD ____ FAIR ____ POOR____ ACTIVITY LEVEL? LOW ____ MED ____ HIGH ____

ARE YOU PREGNANT? YES _____ NO _____

ARE YOU CURRENTLY WORKING? YES _____ NO _____

IF YOU ARE NOT WORKING IS IT BECAUSE OF YOUR INJURY? YES _____ NO _____

I AUTHORIZED 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.

SIGNATURE _____ DATE _____

DATE OF BIRTH _____ PHONE NUMBER _____

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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