

## Patient Information Sheet

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ M \_\_\_\_\_ F

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you?    Married    Divorced    Single    Minor    Widowed    Legally Separated

**Employer Status:** (circle one)  
                          Not Employed    Full Time    Part Time    Student [PT / FT]    Retired

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Nature of Accident:**

- Injured at home, school or recreation
- Injured at work
- Car Accident      State \_\_\_\_\_

Onset Date: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Referring Provider Phone #: \_\_\_\_\_

Referral Source:

- M.D. Referral                       Yellow Pages
- Flyer or Postcard                   Internet
- Friend, if so, who? \_\_\_\_\_
- Other: \_\_\_\_\_

Are you able to work?                      YES / NO

Work Compensation Number (prior authorization number): \_\_\_\_\_

*I authorize the release of any medical or other information necessary to process claims on my behalf. I also agree to be fully responsible for all lawful debts incurred by myself for services received from Saint Marina Physical Therapy Inc, and consent to medical treatment, whether covered by insurance or not.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Medical History Form

Name: \_\_\_\_\_ Age \_\_\_\_\_

Date of Onset: Injury / Problem / Surgery: \_\_\_\_\_

Briefly state previous treatment, if any: \_\_\_\_\_

Do you have now, or have you ever had, any of the following?

Diabetes	YES ___ NO ___	Allergy to Cold	YES ___ NO ___
High Blood Pressure	YES ___ NO ___	Other Allergies	YES ___ NO ___
Pacemaker	YES ___ NO ___	Previous Surgery	YES ___ NO ___
Chronic Headaches	YES ___ NO ___	Seizures	YES ___ NO ___
Kidney Problems	YES ___ NO ___	Metal Implants	YES ___ NO ___
Nervous Disorders	YES ___ NO ___	Dizziness	YES ___ NO ___
Hernia	YES ___ NO ___	Cancer	YES ___ NO ___
Osteoporosis	YES ___ NO ___		
Bone Disease	YES ___ NO ___	Bowel Problems	YES ___ NO ___
Fractures	YES ___ NO ___	Recent Weight Loss	YES ___ NO ___
Bladder Problems	YES ___ NO ___	Circulatory Disease	YES ___ NO ___
Pins and Needles	YES ___ NO ___		

Problems with both arms and both legs at the same time YES \_\_\_ NO \_\_\_

If yes to any of the above, please explain and give appropriate details: \_\_\_\_\_

Are you pregnant now? YES \_\_\_ NO \_\_\_

Are you presently taking any medication? YES \_\_\_ NO \_\_\_

If yes, please list your medications and for what condition: \_\_\_\_\_

Have you had any X-rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder?

YES \_\_\_ NO \_\_\_ If YES, please explain the findings as you understand them \_\_\_\_\_

Is there anything else you think I should know about your general health, or current condition?

Please explain and, if necessary, we can talk about it: \_\_\_\_\_

## Assignment of My Benefits

### Benefit Information:

What is your deductible amount? \$\_\_\_\_\_ and Coinsurance %\_\_\_\_\_ (for services you are seeking)

*If you don't know this information, call the "800" number on your insurance card. The front desk person may be able to assist you.*

### Policy Information:

Patient Name: \_\_\_\_\_ I.D. Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Guarantor Name (if other than patient name): \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_\_

Your Relationship to the Guarantor: \_\_\_\_\_ Parent \_\_\_\_\_ Spouse \_\_\_\_\_ Other: \_\_\_\_\_

Claim Number: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

**St Marina Physical Therapy Inc. 22921 Triton Way Laguna Hills, CA 92655**

If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

### **This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

\_\_\_ A photocopy of this assignment shall be considered as effective and valid as the original

\_\_\_ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

\_\_\_ I authorize the use of this signature on all insurance submissions.

\_\_\_ I authorize St Marina Physical Therapy Inc. to deposit checks made in my name

\_\_\_ I authorize St Marina PT Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf

\_\_\_ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

We attribute our success to the policies and beliefs we uphold.

### **General Patient Policies**

- **Do not be late.** If you are more than 10 minutes late to your appointment you may be asked to reschedule.
- **Give 24-hr advance notice.** A \$10 fee will be applied to your account for any reschedules or cancellations made with a less than 24 hour advance notice.
- **No-Shows are bad.** We understand things happen. If you are unable to keep your appointment please call and let us know. Simply not showing up will result in the loss of all previously scheduled future appointments. New appointments will be allowed on a “first-come, first-serve” basis.
- **Turn cell-phones OFF.** No cell phone or telephone calls during treatment time.

Patients Signature: \_\_\_\_\_

