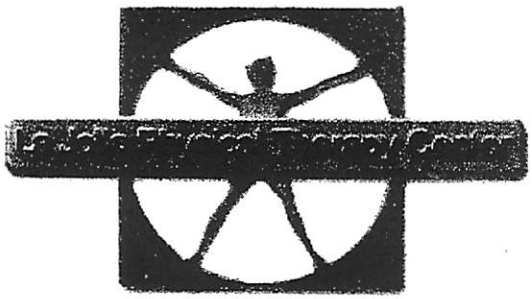


New Patient Intake Form

Appointment Date _____
Time_____

PATIENT INFORMATION

Name _____ Sex_____
Last First
Address _____

_____
City State Zip
Date of Birth _____ Social Security # _____
Home Phone _____ Work Phone _____
Mobile Phone _____ Email _____

Marital Status: Single Divorced Married Separated Widowed Unknown

Employer _____ Emp Phone # _____
Address _____
Occupation _____ Status: Full Time / Part Time

Emergency Contact _____ Phone # _____
Relationship _____

Referring Physician _____ Office Phone # _____
Address _____

Injury Type: Work Auto Home Other _____ Lawyer Involved? Yes / No
Attorney Name _____ Phone # _____
Address _____
Injured Area(s) _____ Date of Injury _____

Signature of Patient _____ Date _____

INSURANCE INFORMATION

Primary Insurance _____
Insured's Name _____ D.O.B _____
Secondary Insurance _____
Insured's Name _____ D.O.B _____

RESPONSIBLE PARTY INFORMATION (if other than patient)

Responsible Party _____
Last First
Relationship of Patient to Responsible Party _____

Address _____

_____

City State Zip

Employer _____ Emp Phone # _____

Address _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Date of Birth _____ Social Security # _____

Signature of Responsible Party _____ Date _____

Medical History Information

Have you received physical therapy treatments for your present condition? **Y / N**

If yes, please state location and date: _____

Please indicate body parts currently affected: _____

Please shade in the scale below measuring the level of pain you are experiencing:

0 5 10

NO PAIN INTOLERABLE

Please list any medication you are currently taking: _____

_____

Have you had a history of any of the following? Please circle appropriate response:

Diabetes	**Y / N**	Allergies to Heat	**Y / N**
High Blood Press	**Y / N**	Allergies to Ice	**Y / N**
Heart Disease	**Y / N**	Other Allergies	**Y / N**
Heart Attack	**Y / N**	Previous Surgery	**Y / N**
Pacemaker	**Y / N**	Hernia	**Y / N**
Headaches	**Y / N**	Seizures	**Y / N**
Kidney Problems	**Y / N**	Metal Implants	**Y / N**
Nervous Disorders	**Y / N**	History of Cancer	**Y / N**
Circulatory Problems	**Y / N**		

If you answered yes to any of the above, please explain and give approximate dates:

_____

The above knowledge is correct to the best of my knowledge.

Signature of Patient/Guardian: _____ Date: _____

Guardian Name, if patient is a minor: _____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made.

We have calculated your **ESTIMATED** patient portion for each visit to be $200.00 - $150.00 This amount is based off of information gathered from your insurance company. The amount stated above will be collected from you before each visit. All additional amounts owed as patient responsibility will be billed to you each month in an itemized patient statement.

We have calculated your **AGREED** patient portion to be $200.00 - $150.00 a visit towards your deductible up to $_____ then $_____ for each visit after the deductible is met.

It is also our policy to charge the rates above as a no show/cancellation fee for any missed visit scheduled and not cancelled at least 24 hours in advance.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. [redacted]

You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

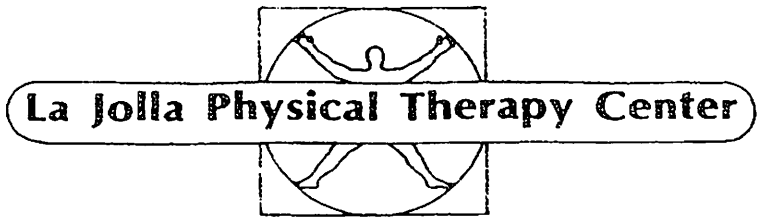
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ **DATE:** _____

Patient, Parent, or Guardian



(858) 454-9769

Privacy Policy Acknowledgment

I have received and reviewed the privacy policy information packet.

_____ _____

Name Date

7450 Girard Avenue La Jolla, California 92037