San Buenaventura Physical Therapy

New Patient Information

Patient Name_____ **Date of Birth**_____ **Age**_____

Social Security Number_____ **Home Phone**_____

Mobile Phone_____ **E-Mail**_____

Sex (circle one): **Male** **Female** **Marital Status** _____

Address_____ **City, Sate, Zip**_____

Emergency Contact_____ **Phone**_____

Whom is the person that referred you to our office?_____

Employer_____ **Occupation**_____ **Work Phone**_____

Address_____ **City, State, Zip**_____

Do you have or have you had the following:

Diabetes?	**Yes_____**	**No_____**
High Blood Pressure?	**Yes_____**	**No_____**
Heart Problems or Disease?	**Yes_____**	**No_____**
Pacemaker?	**Yes_____**	**No_____**
Prior Surgeries?	**Yes_____**	**No_____**
Seizures?	**Yes_____**	**No_____**
Metal Implants?	**Yes_____**	**No_____**
Allergies?	**Yes_____**	**No_____**
Stroke or TIA?	**Yes_____**	**No_____**
Cancer?	**Yes_____**	**No_____**
Do you Smoke?	**Yes_____**	**No_____**
Are you pregnant?	**Yes_____**	**No_____**

If "Yes", please explain_____
_____
_____

Current Medications_____
_____

I authorize payment of medical benefits to San Buenaventura Physical Therapy as indicated on the itemized bill. I authorize San Buenaventura 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 San Buenaventura Physical Therapy is billing my insurance as a courtesy, and that I am ultimately responsible for the charges**.** ***I understand I may be charged a fee of $35 for no shows or cancellations with less than 4 hours of notice prior to the scheduled appointment time.*** This may be waived at the owner's discretion. 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 San Buenaventura 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 or Guardian Signature_____ **Date**_____