4200 Trabuco Road, Suite 180, Irvine, CA 92620 Phone: (949) 651-9199 Fax: (714)730-1882

PATIENT INFORMATION

Patient Name _____ Birth Date _____ Sex M☐ F☐

Address _____ City _____ ST ___ Zip _____

Home Phone _____ Email _____

Cell Phone _____ SS# _____

Marital Status _____ Driver's License # _____ State _____

Employer _____ Occupation _____

Address _____ City _____ ST___ Zip_____

Work Phone _____ Referring Physician _____

Date of Injury _____ Date of Surgery _____ Circle Injury Type: Auto Work Other _____

How did this injury occur? _____

Have you had previous physical therapy for your present condition for which you are to receive treatment here? Yes☐ No☐

If yes, state where: _____ When? _____

Where did you hear about Dorner Physical Therapy? _____

INSURANCE INFORMATION

Primary

Insurance Company _____

Insured Person _____

Birth Date _____

Address _____

City _____ ST ___ Zip_____

Policy # _____

Claim/Group # _____

Phone # _____

Secondary

Insurance Company _____

Insured Person _____

Birth Date _____

Address _____

City _____ ST ___ Zip_____

Policy # _____

Claim/Group # _____

Phone # _____

Do you have or have you had any of the following:

Diabetes……	**Yes☐No☐**	Sensitive to Heat/Ice……..	**Yes☐No☐**
High Blood Pressure…….	**Yes☐No☐**	Pregnant Currently……..	**Yes☐No☐**
Heart Disease……	**Yes☐No☐**	Allergies…….	**Yes☐No☐**
Heart Attack……...	**Yes☐No☐**	Previous Surgery……	**Yes☐No☐**
Pacemaker…….	**Yes☐No☐**	Hernia (any)……...	**Yes☐No☐**
Headaches……	**Yes☐No☐**	Seizures……	**Yes☐No☐**
Kidney Problems……...	**Yes☐No☐**	Metal Implants…….	**Yes☐No☐**
Nervous Disorders……	**Yes☐No☐**	Cancer……..	**Yes☐No☐**
Recent Illness or Surgery……	**Yes☐No☐**	Vision or Hearing Problem……	**Yes☐No☐**

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

_____

_____

Are you presently taking medications? Yes☐ No☐ If yes, please list what medications and for what condition:

_____

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Please review the information you received pertaining to our office policies and the privacy of your health information as outlined in the Patient Information Practices document per HIPAA guidelines.

I have received and reviewed a copy of Dorner Physical Therapy's office policies. I understand and agree to abide by the information provided therein. **I understand that I must give 24 hours advance notice should I need to cancel an appointment or I will be charged $25.**

_____
Initial

I understand that my insurance is billed as a courtesy and that sixty (60) days are allowed for processing, after which I may be held responsible for the balance due. If my account becomes delinquent, I may be held responsible for reasonable attorney fees, court costs, collection costs, and interest at 1.5% per month.

I hereby authorize the physical therapists and staff to render services necessary to the above patient and agree to assume all financial obligations incurred. I also authorize this facility to release information to my insurance company and instruct them to pay Dorner Physical Therapy.

PATIENT OR RESPONSIBLE PARTY ✘_____ **DATE** _____

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Dorner Physical Therapy's Notice of Information Practices. I understand that Dorner Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Dorner Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Dorner Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ ✘_____
Patient Name **Signature**

_____
Date