WELCOME TO WEST MARIN PHYSICAL THERAPY!!!

PLEASE GIVE US YOUR INSURANCE CARDS SO THAT WE MAY COPY THEM.

NAME_____DATE_____
MAILING ADDRESS (PO Box/Street)_____
CITY/STATE/ZIP_____
DATE OF BIRTH_____AGE_____PHONE #s _____
EMPLOYER_____WORK PHONE_____
EMERGENCY CONTACT_____ PHONE_____
REFERRING PHYSICIAN_____
DIAGNOSIS_____ONSET DATE_____
E-MAIL_____

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RELEVANT MEDICAL HISTORY (CHECK IF APPROPRIATE)

__ALLERGIES
__ARTHRITIS
__BOWEL/BLADDER
__CANCER
__DIABETES
__DIZZINESS
__HEADACHES
__HEART DISEASE
__HERNIA
__HIGH BLOOD PRESSURE
__IMMUNE DEFICIENCY
__IMPLANTS/HARDWARE
__KIDNEY PROBLEMS
__LUNG PROBLEMS
__NIGHT SWEATS
__NUMBNESS/TINGLING
__PREGNANCY
__STOMACH PROBLEMS
__STROKE
__SURGERY
__OTHER RELEVANT PROBLEMS:
_____

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MEDICATIONS: (Please include **Name, Dosage, Frequency**) Or let us copy your **Med List.** If you change your **medications** during your course of treatment, let us know.

1._____2._____
3._____4._____

5. HAVE YOU FALLEN IN THE LAST 12 MONTHS? **YES_____NO_____**

6. WHAT IS YOUR PAIN RANGE? **0 1 2 3 4 5 6 7 8 9 10**
(**Please Circle Two Numbers, Low to High)** MILD MEDIUM STRONG

7. WHAT IS YOUR **HEIGHT?** _____ **WEIGHT?**_____

PLEASE TURN TO PAGE 2

BILLING INFORMATION: (PLEASE CHECK ONE)

I'LL BE PAYING WITH CASH_____ CHECK _____CREDIT CARD_____

PRIVATE INSURANCE _____

MEDICARE _____

MEDICARE SUPPLEMENTAL _____

WORKERS' COMPENSATION _____

****

PATIENT AUTHORIZATION FOR MEDICAL BILLING AND POLICIES:

1. I understand that my medical records are confidential and no medical records will be released without my consent.

2. For insurance billing, I hereby authorize West Marin Physical Therapy to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance claims.

3. I hereby authorize and direct my insurer to issue check(s) payable to West Marin Physical Therapy. **I understand that regardless of my insurance benefits, if any, that I am financially responsible for the fees for services rendered. I also understand that it is my responsibility to know what my therapy benefits are for my particular insurance policy.**

4. I am also aware that unless I am sick, **a cancellation without 24 hours notice or failure to keep an appointment will result in a $90 charge.**

THANK YOU!!!!!

_____ _____

PATIENT'S SIGNATURE DATE