

Welcome to the  
**PHYSICAL REHAB & AQUATIC CENTER OF HEMET**

**NEW PATIENT INFORMATION**

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

Family/Primary Care Physician: \_\_\_\_\_ Doctor Referred By: \_\_\_\_\_  
Social Security#: \_\_\_\_\_ Drivers Lic.#: \_\_\_\_\_ State: \_\_\_\_\_

**PATIENT INFORMATION** (Please Print)

	Birthdate: _____	Age _____	___ Male ___ Female
<b>Patient's Name:</b> _____			
First	M.I.	Last	
Address: _____		City: _____	State: <u>CA</u> Zip: _____
Home Phone#: _____	Work Phone#: _____	Cell Phone#: _____	
Are you Employed: ___ Yes ___ No		Occupation: _____	
Employer: _____			
Address: _____			
___ Married ___ Single ___ Widowed ___ Divorced		Name of Spouse: _____	
Spouse Employed By: _____		Occupation: _____	
Employers Address: _____		Phone: _____	
In Case of Emergency, Notify: _____		Phone: _____	
Name and Address of Attorney: _____			

**IF PATIENT IS A MINOR, PLEASE FILL IN THE FOLLOWING:**

Responsible Party (Parent/Guardian): _____		
D/L#: _____	State: _____	Social Security #: _____
Responsible Party's Employer: _____		
Employer's Address: _____		
Phone: _____		

**SIGNATURE ON FILE**

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my therapist to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment direct to Physical Rehab Center of Hemet.
- I permit a copy of this authorization to be used in place of the original.

NAME (Please print): \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES of this form**

**Return ALL paperwork along with your *Insurance Card* and a *Picture I.D.* (i.e. Drivers License, School ID, State ID, Work ID, etc.) Thank you**  
**PREVIOUS HEALTH CONDITIONS**

Have you previously had therapy for your PRESENT condition? \_\_\_ Yes \_\_\_ No

If so, when and where: \_\_\_\_\_

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

Diabetes	___ Yes ___ No	Stroke	___ Yes ___ No
Do you smoke	___ Yes ___ No	Sensitive to heat/ice	___ Yes ___ No
High Blood Pressure	___ Yes ___ No	Pregnant	___ Yes ___ No
Heart Disease	___ Yes ___ No	Allergies	___ Yes ___ No
Heart Attack	___ Yes ___ No	Previous Surgery	___ Yes ___ No
Pacemaker	___ Yes ___ No	Hernia	___ Yes ___ No
Headaches	___ Yes ___ No	Seizures	___ Yes ___ No
Kidney Problems	___ Yes ___ No	Metal Implants	___ Yes ___ No
Nervous Disorders	___ Yes ___ No	Cancer	___ Yes ___ No
Emphysema	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Hepatitis	___ Yes ___ No	Depression	___ Yes ___ No

If Yes on any of the above, please explain and give approximate dates: \_\_\_\_\_

**MEDICATIONS**

Are you presently taking ANY medication (including Aspirin, Tylenol, Ibuprofen, Vitamins, etc.)? \_\_\_ Yes \_\_\_ No

If Yes, please list what medication and for what conditions:

Medicine: _____	Condition: _____
Medicine: _____	Condition: _____
Medicine: _____	Condition: _____
Medicine: _____	Condition: _____
Medicine: _____	Condition: _____
Medicine: _____	Condition: _____

**REFERRAL SOURCE**

\_\_\_ Primary Doctor \_\_\_ Specialist Doctor \_\_\_ Yellow Pages \_\_\_ Newspaper \_\_\_ Work Comp  
\_\_\_ I am a Former Patient \_\_\_ Referred by a Former Patient (Last Name only: \_\_\_\_\_)  
\_\_\_ Attorney \_\_\_ Drive-By \_\_\_ Other: \_\_\_\_\_

**TREATMENT CONSENT - PERMISSION TO RELEASE INFORMATION**

I do hereby consent to Physical Therapy treatment for myself/son/daughter \_\_\_\_\_ (patients name). I also authorize you to furnish my doctor and/or insurance company with pertinent information regarding my their illness or accident. I understand that I am financially responsible for all charges incurred while receiving treatment. I also understand that overdue accounts will be subject to a finance charge of 1½ % per month. A PAYMENT MUST BE MADE ON THIS ACCOUNT EVERY THIRTY DAYS REGARDLESS OF INSURANCE COVERAGE.

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_