CORE Physical Therapy:
Fullerton Orange Anaheim Hills Temecula
New Patient Form

My insurance is an: HMO PPO Medicare Work Comp Lien Other:_____

Name:_____ Date:_____ DOB: _____ Gender Preference: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Number: _____ Email: _____ Drivers Lic #: _____

Employer: _____ Occupation: _____ Phone#: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Referring Physician: _____ Family Physician: _____

Financially Responsible Party: (N/A if patient)

Name: _____ Relationship: _____ DOB: _____

Insurance Information:

Insurance Co: _____ ID#:_____ Group#:_____

Secondary Insurance:

Insurance Co: _____ ID#: _____ Group#: _____

Language Preference: _____ Interpreter: Needed _____ Refused: _____

Assignment of Insurance Benefits and Acknowledgments:

1. Regardless of any third party contract agreement you feel we may have, the patient is ultimately responsible for any services rendered and/or products dispensed at or from CORE Physical Therapy. We will of course attempt to bill your insurance for any services rendered, but any balance or denied charges are the responsibility of the patient. You will also be responsible for any legal or collection fees incurred in collecting any unpaid balances.
2. If you would like us to bill your insurance, then it is understood that you hereby assign to CORE Physical Therapy any and all benefits from your insurance carrier.
3. By signing below you authorize CORE Physical Therapy to release any information necessary to insure processing of your billed claims. This includes but is not limited to any third party payors, attorneys, employers, etc…
4. Patient acknowledges that they have received a read the HIPAA Compliance Practices posted and have received a copy if one has been requested.

_____ _____

Patient Signature: Date:

Injury Information

Is condition due to an injury? Yes No **If no, skip to section B**. If yes, please see below:

Was the injury work related? Yes No Describe injury: _____

Did you notify employer? Yes No If so, who did you notify? _____

Claim #:_____ Phone#:_____

Are you still working? Yes No Describe duties: _____

B. Was injury due to auto accident? Yes No If yes, please see below:
Date of accident: _____ Auto Insurance Name: _____ Policy #:_____

Phone #:_____ Reported on:_____ Lien Signed: Yes No

Attorney name: _____ Phone #:_____

Were you hospitalized? Yes No Date: _____ Where:_____

Have you had to have surgery? Yes No Date: _____ Any other surgeries: _____

_____

Have you had any falls in the past 6 months? Yes No Date: _____ Where:_____

What other types of doctors/health care providers have you seen for this condition? _____

_____

Have you had any of the following diagnostic tests? X-rays: Yes No CT Scan: Yes No
MRI: Yes No Injections: Yes No

Which activities make pain worse? During Exercise After Exercise Sitting Walking Coughing
Sneezing Bending Forward Bending Backward Other: _____

How did pain start? Suddenly Gradually Lifting Pulling Bending No Reason Other:_____

Which of these reduces the pain? Lying down Sitting Standing Walking Pain Injection Medication
Other:_____

Patient Name: _____ Date: _____

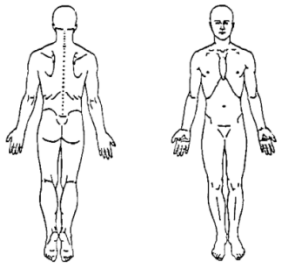
Patient or Responsible Party Signature: _____

Patient Health History

Patient Name:_____ Age: ___ Date: _____ When did pain start?_____

Pain/Symptoms:
On the body diagram, indicate you region of pain using these symbols:

(X) Sharp (+) Numb Tingling (#) Dull/Ache (B) Burn Pain is (0-10) _____



List all medications currently taking: Dosage Frequency How Taken Prescribed by:

_____
_____
_____
_____
_____
_____
_____

(If additional meds, please ask for 2nd page)

Do you have any of the following? (Please circle all that apply)

Allergies	Diabetes	High Blood Pressure	Heart Disease	Stroke
Cancer/Tumors	Lung Problems	Arthritis/Joint Difficulties	Fever/Chills	Fatigue
Frequent Cramping	Visual Problems	Immunity Disorders	Night Sleep Disturbance	
Pacemaker	Joint Replacement	Change in Bowel Habits	Memory Changes	
Pain 24 Hrs	Awake in Pain	Increased Thirst	Change in bladder habits	
Nausea/Vomiting	Increase in hunger	Indigestion /Heartburn	Change in stool color	
Weakness	Rectal bleeding	Frequent urination	Frequent Bruising	
Dizziness/Blackouts	Seizures	Nerve Disorders	Frequent Bleeding	
(Ir)regular Headaches	Pregnant			

Smoke: Yes No _____/day Drink Yes No _____/day

Release of Information

I _____ herby authorize the staff at CORE Physical Therapy, to release any medical, scheduling and/or billing information on me to the following individual(s) should they request it:

1. _____ is my _____ DOB: _____
2. _____ is my _____ DOB: _____
3. _____ is my _____ DOB: _____

This will serve for staff members to provide questions regarding the patients care, make or edit appointments or any financial concerns. This is not authorization for release of medical records. I release all CORE Physical Therapy staff members from any liability that may arise from the release of such information. Should I wish to obtain copies of my records, I will do so by signing a Records Release and paying for required fee. **Initials:_____**

Insurance Benefit Information

Your insurance benefits have been quoted to us by your insurance company and we assume NO liability for any errors made by your carrier in their information provided. The fact that your insurance has been verified does NOT release you or is in no way in lieu of your responsibilities or our office. Your acceptance of medical care from our office will suffice as your agreement to the above in lieu of your signature provided.

Healthcare Directive

Our office can have a healthcare directive available to you should you choose to sign one. Please let us know if you would like to complete one or if you would prefer to decline. **Decline: Yes No**

Consent for Treatment

Knowing that I am suffering from a condition requiring diagnostic or medical treatment, I hereby consent to care by CORE Physical Therapy as they may deem necessary by their judgment. I do hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand and expect that the care I receive by CORE Physical Therapy will meet customary standards. I do understand that medicine is not an exact science and acknowledge that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination of treatment. I hereby authorize CORE Physical Therapy to retain any records for use, for research and for teaching purposes. Should I choose to refuse treatment that has been suggested to me, I will not hold CORE Physical Therapy or any individual responsible for any consequences resulting from my decision.

Patient Signature: _____ **Date:** _____

If this consent is signed by a representative or responsible party, please indicate the following:

Responsible Party Name: _____ **Relationship to Patient:** _____