

EL CAJON THERAPY ASSOCIATES

PATIENT INFORMATION

Date_____

Federal regulations require that a medical history must be included in all patients' medical history records.
PLEASE ANSWER ALL QUESTIONS ON EVERY PAGE OF THESE FORMS.

PATIENT'S NAME: Mr. Mrs. Miss. Ms. _____

Home Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____

Age_____Birth Date_____SS#_____Drivers License #_____

Occupation_____Place of Employment_____

Employment Address_____

Person legally responsible, or if a minor, name of parent or legal guardian_____

Name of Spouse_____Occupation_____

Place of Employment_____

Employment Address_____Phone_____

Referred to this office by_____Next Appointment_____

Primary Care Physician_____Phone_____

Are you currently being seen by another doctor or chiropractor? Yes No

If yes, please explain and give name_____

Reason for Physical Therapy_____

Date of onset/Injury_____

Date and Type of Surgery_____

Have you ever received Physical Therapy treatments in the past for this or another condition? Yes No

What condition and where?_____

Have you ever been seen in this office before? Yes No

Please answer A, B, or C completely:

A) Is this a Work Related Condition? Yes No

If YES:

Date of Injury _____ Where _____

What occurred? _____

Name of Employer at Time of Injury _____

Did you report this to a supervisor or employer? Yes No

Name of Claims Adjuster _____ Phone _____

Claim # _____ Work Comp Carrier _____

Address _____

B) Do you have insurance that will cover Physical Therapy? Yes No

Name of Insured _____ Insurance Name _____

SS# of Insured _____ Employer/Group Name _____

Group Number _____ Insurance Number _____

Co-Payment Amt _____ Has the Yearly Deductible been met? _____

C) If this Condition is related to a Car Accident; Please complete the following:

Date of Injury _____ What Happened _____

Insurance Company covering Medical Costs _____

Name of Insured _____ Claims/Policy # _____

Insurance Address _____

Name of Attorney _____ Phone _____

Address _____

Emergency Contacts:

1st Contact _____ Phone _____

2nd Contact _____ Phone _____

PLEASE FILL OUT THE FOLLOWING MEDICAL INFORMATION COMPLETELY:

Do you have or have you ever had any of the following??

Diabetes	Yes	No
Cancer	Yes	No
Heart Attack	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
High Blood Pressure	Yes	No
Pacemaker	Yes	No
Hernia	Yes	No
Seizures	Yes	No
Allergies	Yes	No
Allergy to heat or cold	Yes	No
Currently Pregnant	Yes	No
Kidney Problems	Yes	No
Neurological Disorder	Yes	No
Psychological Disorder	Yes	No
Infectious Disease	Yes	No
Hepatitis	Yes	No
Carrier	Yes	No
Headaches	Yes	No
Previous Surgeries	Yes	No

If you have answered Yes to any of the above, please explain and give approximate dates:_____

Current Medications:

The above information is correct and true to the best of my knowledge. I authorize this physical therapy office to furnish information to any insurance company or to a designated attorney. I agree that a Photostat of this authorization shall be valid as the original. I authorize that this office is due payment for services rendered.

I authorize this office to supply my Physical and/or Occupational Therapy Services.

Patient's Signature

Date

El Cajon Therapy Associates

590 South Magnolia Ave

El Cajon, CA 92020-6011

(619) 444-6113 FAX (619) 444-8205

ASSIGNMENT OF BENEFITS

I, _____, authorize assignment of payment directly to **El Cajon Therapy Associates** THE BASIC BENEFITS, as well as MAJOR MEDICAL BENEFITS herein specified and otherwise payable to me.

I authorize the "Release of any Medical Information" necessary to process my claims. I understand I am financially responsible to El Cajon Therapy Associates for all charges.

THIS AUTHORIZATION SHALL BE VALID AS MY INSURANCE FORM. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Signature_____Date_____

All Physical Therapy given in this office is under the supervision of a Registered Physical Therapist.



El Cajon Therapy Associates

East County's Best

El Cajon Therapy Associates Newsletter

NEWSLETTER OPT-IN AGREEMENT

Clinic

**El Cajon Therapy
Specialists**
619.444.6113

Thank you for choosing El Cajon Therapy Associates. We have created a unique newsletter for you. Each month you will be provided valuable information about services and post therapy care necessary for healthy, long term success of recovery.

We will include information about health and fitness.

Learn about treatments, medical conditions, Kids' wellness, preventive programs and more.

E-mail Address: _____
Please Print

Patient Name: _____
Please Print

Sign: _____

By submitting this information, I confirm that I am only acting for my own e-mail account, or one for which I have express authority to submit this request. Once the subscription is confirmed, I agree to accept newsletter e-mails from El Cajon Therapy Associates and my e-mail address will not be used for any other purpose. I understand that I may unsubscribe at any time by following your instructions and that I may still receive a limited number of e-mails while this request is processed.

**EL CAJON THERAPY ASSOCIATES WILL NOT SHARE,
DISTRIBUTE, OR SELL YOUR E-MAIL ADDRESS.**