

State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780

(714)544-2188 * (714)544-2189 Fax

sotapt@sbcglobal.net * www.sotapt.com

Name (Last, First, Middle) _____ Insured's Name (Last, First, Middle) _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Social Security # _____ Social Security # _____

Date of Birth _____ Date of Birth _____

Phone (home) _____ Phone (home) _____

Phone (wireless) _____ Phone (wireless) _____

E-mail _____ E-mail _____

Preferred Appt Confirmation Method (please check one):

Employer _____ Phone ___ E-Mail ___ Text ___

Address _____ Height _____ Weight _____ Male ___ Female ___

City, State, Zip _____ Married ___ Single ___ Divorced ___

Phone _____ Occupation _____ Sport(s) _____

Emergency Contact Name: _____ Date of injury _____

Emergency Contact Number: _____ Area of injury _____

Referring Doctor _____ Insurance _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

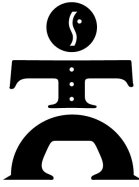
Specialty _____ Policy# _____

I consent to physical therapy services rendered at State-of-the-Art Physical Therapy. I also consent to physical therapy services rendered at State-of-the-Art Physical Therapy of my minor child in my absence. Name of minor child _____ Initials _____

I understand that it is my responsibility to inform the physical therapist/staff about any health problems or allergies I have as well as any drugs or medications I am taking. I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services is made. Initials _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed above and certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or any changes in the above information as soon as possible. I AM AWARE AND UNDERSTAND THAT IF ANY CHECKS ARE MAILED TO MY HOME, I SHALL PROMPTLY DELIVER THE CHECK TO STATE-OF-THE-ART PHYSICAL THERAPY. IF CHECKS ARE NOT DELIVERED, I WILL BE RESPONSIBLE FOR ALL CHARGES IN FULL. I hereby authorize State-of-the-Art Physical Therapy to furnish my insurance carrier or others with full information regarding treatment rendered when so requested. I hereby authorize direct payment of my insurance benefits to State-of-the-Art Physical Therapy, otherwise payable to me, for services rendered. I agree that a copy of this letter is as valid as the original. Initials _____

Signature _____ Date _____



State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780

(714)544-2188 * (714)544-2189 Fax

sotapt@sbcglobal.net * www.sotapt.com

Confidential Health History

Medications: List all medications you are currently taking

Allergies: List all allergies

Medical History: Check the medical conditions you have or have had in the past

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

Symptoms: Check the symptoms you currently have or have had in the past year

- | | | | |
|--|--|---|--|
| GENERAL: | MUSCLE/JOINT/BONE: | GASTROINTESTINAL: | EYE, EAR, NOSE THROAT: |
| <input type="checkbox"/> Chills | (pain, weakness, numbness in) | <input type="checkbox"/> Appetite poor | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Arms | <input type="checkbox"/> Bloating | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Legs | <input type="checkbox"/> Bowel changes | <input type="checkbox"/> Crossed eyes |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hands | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Feet | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Neck | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Back | <input type="checkbox"/> Gas | <input type="checkbox"/> Ear discharge |
| <input type="checkbox"/> Loss of sleep | GENIOT-URINARY: | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nausea | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Persistent cough |
| CARDIOVASCULAR: | SKIN: | <input type="checkbox"/> Vomiting including blood | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bruise easily | WOMEN: | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hives | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Vision – flashes or halos |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Itching | <input type="checkbox"/> Extreme menstrual pain | |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Change in moles | <input type="checkbox"/> Hot flashes | |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Rash | <input type="checkbox"/> Currently pregnant | |
| <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Scars | | |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Sores that won't heal | | |
| <input type="checkbox"/> Varicose veins | | | |

*Interested in weight loss? Yes No

*Interested in nutritional supplements for optimal health? Yes No

State-of-the-Art Physical Therapy has my authorization to request from a personal physician, hospital, clinic, etc. information regarding my medical history, physical condition or diagnosis when deemed necessary.

To the best of my knowledge, the foregoing are correct and complete.

Name _____ Date _____



State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780

(714)544-2188 * (714)544-2189 Fax

sotapt@sbcglobal.net * www.sotapt.com

HOW DID YOU FIND OUT ABOUT US?

This information is used to help us service our clients better.

(Please Print)

Your name: _____

Date: _____

(Please Check and Complete all that Apply)

Referred by a friend or family member. Name: _____

Referred by Dr or other health care professional: Name: _____

Referred by a current or former patient of SOTA PT. Name: _____

Web site search. Search term: _____

Browser used (circle one): Google / Yahoo / Bing / Chrome / Other

Web site or web link (check all that apply):

www.sotapt.com

www.tustinphysicaltherapist.com

www.physicaltherapists.com

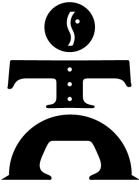
Yelp Link

Alter G Website Link

K-Laser Website Link

Other Website Link: Name: _____

Other Method: _____



State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780

(714)544-2188 * (714)544-2189 Fax

sotapt@sbcglobal.net * www.sotapt.com

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

Cancellation/No Show Policy

I agree to inform State-of-the-Art Physical Therapy of my cancellation by 7:00 PM the business day prior to my appointment. Should I miss my appointment at State-of-the-Art Physical Therapy or fail to inform them within the time frame referenced above, I understand that I will be responsible for a \$20 fee per incident.

Patient Name (Print) _____

Patient's Legal Guardian _____

Signature _____ Date _____