PREMIER
Physical Therapy & Associates

Patient Demographics

First Name:_____ Last Name:_____ Date of Birth:_____ Age:_____ ☐ M ☐ F

Phone Number: _____ Email:_____

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

(If under 18) Parent or Guardian

Name:_____ Date of Birth:_____ Relationship:_____

Phone Number: _____ Email:_____

Emergency Contact check if same as above ☐

Name:_____ Phone Number:_____ Relationship:_____

How did you hear about us?

☐ Physician ☐ Family/Friend ☐ Social Media ☐ Website ☐ Other:

CONSENT FOR TREATMENT

I hereby authorize the providers at Premier Physical Therapy & Associates to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I understand that it is fully my responsibility to be aware of what my private insurance covers and what I may/or may not be responsible for at the end of my treatment. I understand that I am financially responsible for any amount **NOT** covered by my contract.

I, the undersigned, authorize payment of medical benefits to Premier Physical Therapy & Associates for any services furnished to me by the provider. I also authorize you to release to my insurance company or their agents information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____

Patient or Patient Representative

No-Show / Cancellation Policy - Please Read Carefully

We understand emergencies, and other scheduling conflicts occur and can be unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs. Due to our 60-minute treatments, missed appointments are an inconvenience to your physical therapy, the clinic and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. 24-hour notice allows us to place another patient in your cancelled appointment period to receive needed treatment.

2. Patients who do not attend a scheduled appointment and do not provide 24-hour notice to change a scheduled appointment may be responsible for a $20.00 office visit charge. **This charge will not be covered by insurance.**

3. Your treatment plan has been established by your physician and physical therapist to get you back to your regular activities as quickly as possible. Missing appointments may delay that process and may prolong recovery.

4. After missing **three** appointments without notice, you would not be allowed to schedule any appointments in advance.

Thank you for providing our office and patients with this courtesy

Signing below indicates you understand and agree to the terms of this policy.
If you refuse to sign you will not be able to schedule in advance, you may only schedule on the same day you call.

_____ _____

Patient or Patient Representative Date

OXNARD
1160 NORTH VENTURA RD
OXNARD CA 93030

MOORPARK
6591 COLLINS DR SUITE E8
MOORPARK CA 93021

PREMIER
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MEDICAL HISTORY

Patient Name: _____ D.O.B. _____ Date: _____

****Is this injury a result of a work or automobile accident? YES / NO**
If yes, have you taken any legal action regarding your claim? YES / NO **If yes, has it been settled? YES / NO**

Please briefly describe the history of your present condition/mechanism of injury:

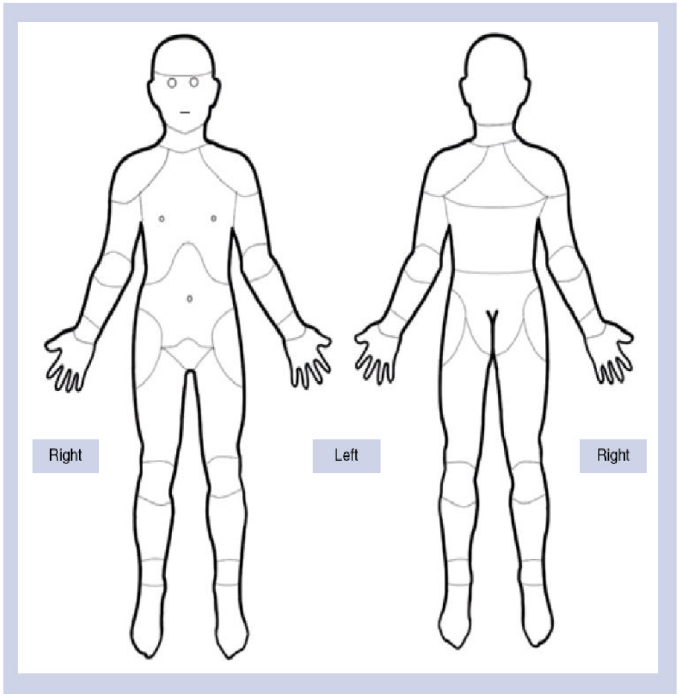
_____
_____
_____

How would you describe your symptoms (circle all that apply):
Aching Burning Shooting Sharp Numbness Tingling
Throbbing Spasms Tightness Dull Constant
Worse in the morning Worse midday Worse at night

Please rate the severity of your pain/symptoms by circling the appropriate number on a scale of 0 to 10 with 0 being no pain/symptoms and 10 being severe pain/symptoms.

Pain at worst: 0 1 2 3 4 5 6 7 8 9 10
Pain currently: 0 1 2 3 4 5 6 7 8 9 10
Pain at best: 0 1 2 3 4 5 6 7 8 9 10

Please circle where your pain is located



Please circle ALL illness or conditions which apply to you:

Alzheimer's/Dementia	Osteoporosis/ Osteopenia	High/Low Blood Pressure
Emphysema	Cerebral Vascular Accident	Parkinson's Disease
Lupus	Fracture or Suspected Fracture	Depression
Asthma	Osteo/Rheumatoid Arthritis	HIV/AIDS
Epilepsy/Seizures	Chronic Fatigue Syndrome	Traumatic Brain Injury
Multiple Sclerosis	Heart Disease	Diabetes
Cancer_____	Pacemaker	Immunosuppression
Fibromyalgia	Chronic Pain Syndrome	Other:_____

Please list any prior Serious Injuries, Falls or Surgeries you have sustained and their approximate date(s):

1._____ 2._____
3._____ 4._____

Please list any recent tests and results you have had (X-ray, MRI, CT-Scan, Nerve Conduction):

1._____ 2._____
3._____ 4._____

Please list all medications you are currently taking, including any herbal medication, vitamins or supplements.

1._____ 3._____ 5._____
2._____ 4._____ 6._____

Patient Goals: What do you hope to achieve by attending physical therapy?

_____
_____

I certify that the information listed above is true and accurate to the best of my knowledge.

Patient Signature:_____