

PATIENT INFORMATION AND ACKNOWLEDGEMENT FORM			
NAME:	Male/Female Date:		
Address: Street City			
Phone- Home: City	State Zip Cell:		
Social Security Number: Birth	date: Age:		
Do you want to be e-billed? Y N Email address:			
Emergency Contact Person:	Relationship Phone		
Name of Parent or Spouse:			
Language of preference: English/Spanish/Other			
Responsible Party/Parent/Guardian Name:			
Phone: Home:Ce	l:Work:		
Address:	01-11-		
Street City  EMPLO	State Zip  OYMENT		
	Job title:		
	Phone: Ext:		
Can we call you at work if necessary? Y N	Are you currently working? Y N		
Parent/spouse employer:			
<u> </u>			
INSURANCE	NFORMATION		
TYPE: Private Medicare Worker's Comp	Other		
	SICIAN		
Primary Care Physician:	Referred by:		
Date of injury/surgery: Date	e of next doctor visit?		
Any previous PT for current problem? Yes No What was done/what was outcome?			
Any chiropractic treatment? Y N Number of visits: Any other form of treatment:			
Any previous injury to this area? Y N Was this a work related injury? Y N Is case open/closed?			
Have you had Physical or Speech Therapy this year? Y N with whom:			
Have you had or are you having Home Health? Y N If yes, with whom:			
What was Home Health discharge date?:			

HISTORY			
Do you have/or have you had any	of the followir	ng:	
High Blood Pressure (reading/) Heart Disease Heart Attack Pacemaker Diabetes Headaches Nervous/Psychological Disorder Hearing Problems Asthma/Respiratory Problems Tuberculosis (Year) Currently pregnantmonths Active Infections	Yes No	Sensitive to ice/heat Allergies Hernia Seizures Metal Implants Dizziness/vertigo Cancer Incontinence Neurological Disorder Osteoarthritis/Osteoporosis Smoker AIDS Hepatitis A/B/C	Yes No
If yes to any of the above please expl	ain & give appr	oximate date:	
Past surgeries:			
Medications taken:			
What is your occupation & physical re	quirements of j	ob:	
Do you have difficulty with any of the	ollowing activit	ies? (Check all that apply & specif	y distance, time, etc. of the limits)
Standing	Sleeping	Sitting _	
Walking	Driving	Lifting	
Personal Care	Other		
What benefits do you expect to gain for	rom physical th	erapy?	
The above information is correct to the be I have read and fully understand Santa Mathat SMVPT may use or disclose my persevaluating the quality of services provided the right to restrict how my personal health notify the practice. I also understand that agree to requests for restrictions. I hereby authorize the use and disclosure Practices. I understand that I retain the rig I hereby authorize my insurance company responsible for all charges regardless of it I authorize SMVPT to contact former proving Medicare cap.	aria Valley Physiconal health information is un and any administration is unstantially will constant to revoke this assurance coverage.	cal Therapy Group (SMVPT) Notice of mation for the purposes of carrying out strative operations related to treatment used and disclosed for treatment, paymider requests for restriction on a casemealth information for purposes as note authorization by notifying the practice of SMVPT medical benefits otherwise page.	treatment, obtaining payment, or payment. I understand that I have tent, and administrative operations if I by-case basis, but does not have to d in SMVPT Notice of Information in writing at any time.  ayable to me. I understand that I am

### **SHORT-FORM McGILL PAIN QUESTIONNAIRE**

Patient name:				Date:	
	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	Severe	
Throbbing	(0)	(1)	(2)	(3)	
Shooting	(0)	(1)	(2)	(3)	
Stabbing	(0)	(1)	(2)	(3)	
Sharp	(0)	(1)	(2)	(3)	
Cramping	(0)	(1)	(2)	(3)	
Gnawing	(0)	(1)	(2)	(3)	
Hot-Burning	(0)	(1)	(2)	(3)	
Aching	(0)	(1)	(2)	(3)	
Heavy	(0)	(1)	(2)	(3)	
Tender	(0)	(1)	(2)	(3)	
Splitting	(0)	(1)	(2)	(3)	
Tiring-Exhausting	(0)	(1)	(2)	(3)	
Sickening	(0)	(1)	(2)	(3)	
Fearful	(0)	(1)	(2)	(3)	
Punishing-cruel	(0)	(1)	(2)	(3)	

A. Please make an "X" on the line below to show how ba	d your pain is right now.
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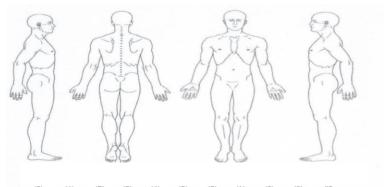
No pain |-----| Worst possible pain

- B. Please check the <u>one</u> descriptor that best describes your present pain.
  - No pain 0
  - Mild 1
  - Discomforting Distressing

  - Horrible
  - Excruciating
- C. Is your pain? (check one word)

Brief	Intermittent	Continuous	
DHEI	11116111111116111	COHUHUUUS	

Please indicate location of pain:



#### **Medical Release Form**

If you have had medical testing (X-rays, MRI, etc.) or surgery related to the current diagnosis, please PRINT your name below so that we may review these reports.

Patient Name:	
Date of Birth:	
Place of service:	
You are hereby authorized to release to Santa	Maria Valley Physical Therapy Group the report(s) requested below.
Signature	Date
Report requested:	
DATE OF SERVICE:	

Please fax the requested report(s) to (805) 349-7206 or mail to ... Santa Maria Valley Physical Therapy Group 820 East Enos Drive, Santa Maria, CA 93454

## Santa Maria Valley Physical Therapy Group Inc.

## **DESIGNATED INDIVIDUALS AUTHORIZATION FORM**

I hereby authorize one or all of the designated parties below to request and receive the release of any protected information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before release of any information.

Authorized Designees:		
Name:	Relationship:	
Patient Name (Print):		
Patient Signature:		
Date:		



Todd Martin PT Jared Bailey PT
Samantha Stollberg PT, GCS
Tom Meenzhuber PT John Hollinshead PT John Hinds PT
Karen Bailey PT Adrian Asencio OT R/L, CHT

www.smvpt.com

# **CREDIT CARD PRE AUTHORIZATION FORM**

I authorize SANTA MARIA VALLEY PHYSICAL THE any services provided to	•	9 ,	
Please initial each line showing you have read and un	nderstand.		
Fees for services not paid by guardian, patient,	or patients insurance within 90	days.	
Co-pays not paid at the time service was render	red.		
Balance of any charges that were not covered b	y patients insurance.		
Name of patient:			
We will bill your insurance as a courtesy to you, howe or partial insurance payments.  Terms of Agreement: Santa Maria Valley PT Group payment services. This agreement is to remain in effereceives written notification of its termination and has	reserves the right to refuse or ect until Santa Maria Valley Phy	terminate your automation	c credit card
Patient Name:			
Cardholders Name (as it appears on o	eard:		
Cardholders Billing Address:			
□ Visa □ Mastercard	☐ American Express	☐ Discover Card	
Credit Card Number:			
Expiration Date:	CVi	#:	