



Kern & Associates Physical Therapy
2901 Wilshire Blvd. Ste 440
Santa Monica, CA 90403
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Patient Information Form—Medicare

First Name: _____ Date: _____
Last Name: _____ Birth Date: _____
Street Address: _____ Sex (circle one) Male Female
Street Address 2: _____ SSN _____
City: _____ State: _____ Zip: _____
Home Phone# _____ Cell # _____ Work # _____
Referring Physician: _____ Phone Number _____
How did you hear about us? _____ E-Mail _____

Emergency Contact: Not Living With You

Name: _____ Phone Number: _____
Relationship: _____

Medicare / Secondary Insurance Information

***Have you or are you receiving home health care? Yes No

Secondary Ins. Co: _____ Phone # _____
Name of Insured: _____ Insured SSN: _____

Patient Authorization ** Please read carefully**

NO SHOW / CANCELLATION POLICY

I understand I will be charged a minimum of \$40.00 for No Shows or Cancellations of less than 24 hours. I understand that I am responsible for any treatments not covered by Medicare due to any type of home health care I may or are currently receiving.

CONSENT

I authorize Kern & Associates Physical Therapy to provide my treatment as prescribed by my physician.

PAYMENT OF BENEFITS TO KERN & ASSOCIATES PHYSICAL THERAPY

I hereby authorize my insurance benefits to be paid directly to Kern & Associates Physical Therapy. I understand I am financially responsible for non-covered services and all insurance deductible. I also authorize Kern & Associates Physical Therapy to release any information my insurance company may request.

Signature

Date

A photocopy of this authorization will be considered as valid as the original

Patient History

Name: _____ Date: _____

Sex: M F Birthdate: _____

Have you ever had or currently have:	If yes, please explain:	Family History?
High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart or Circulation Disorder <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizzy Spells <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Arthritis/Osteoarthritis <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Osteoporosis <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Immune Deficiency Disease <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Incontinent of Bowel or Bladder <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Abnormal Vision or Hearing <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Angina or Chest Pain <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of Breath <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Urinary Tract Infection <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Metal Implant or Pacemaker <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Unusual Weight Gain/Loss <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
Other <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes

Please list surgeries, provide procedures and dates where possible: _____

Please list any accidents or injuries: _____

Please list recent diagnostic studies (i.e. CAT scans, MRI, X-Rays): _____

Other problems that have been diagnosed by a physician? No Yes

Please list all medications you are now taking: _____

(For women only) Are you now pregnant? No Yes Date of last menstrual cycle: _____

Have you ever taken steroids or anti-coagulants for an extended period of time? No Yes

Have you ever had physical therapy treatment before? No Yes

If yes, please indicate where and for what problem: _____

What are your goals in physical therapy? _____