AUM Physical Therapy & Yoga Center
Dhaval Buch, P.T.

1002 Calloway Drive, Bakersfield, CA 93312
(661) LUV4-AUM 588-4286 • Fax 588-9986

PATIENT INFORMATION

	Last	First	Middle Initial	Marital Status	Sex	Age	Date of Birth	Social Security Number
Name								

Address ______________________________
Number and Street City State Zip Phone

Insurance Coverage? Yes ☐ No ☐ E-Mail Address: ____________ Cell Phone: ____________

Name of Employer ______________________________

Employer's Address ______________________________
Number and Street City State Zip Phone

Occupation ____________ How Long Employed? ____________

If Not Employed, Source of Income: ______________________________

Spouse's Name ____________

Occupation ____________ Date of Birth: ____________ Social Security # ____________

Employer's Name and Address ______________________________
Number and Street City State/Zip Phone

If Student; Name of School ______________________________

Nearest Relative / Friend (Not living in the home) ______________________________
Name Relationship Phone

INSURANCE INFORMATION

Primary Insurance: ____________
Name of Insurance

Secondary Insurance: ____________
Name of Insurance

AUTO ACCIDENT / PERSONAL INJURY INFORMATION

☐ **On the Job** ☐ **Traffic Accident** ☐ **At School** ☐ **At Home** ☐ **Other**____________

Insured Name: ____________ Insurance Carrier: ____________

Claim Number: ____________ Insurance Address: ____________

Adjuster ____________ ____________

Date of Injury: ____________ Telephone: ____________

Do you have an attorney for this case? **Yes** ☐ **No** ☐

Attorney Name: ____________ Attorney Phone: ____________

AUTHORIZATION FOR MEDICAL TREATMENT / ASSIGNMENT OF BENEFITS / MEDICAL LIEN

Authorization for Medical Treatment: I hereby authorize AUM Physical Therapy & Yoga Center, Inc. to administer and order any treatment and perform such procedures as may be deemed necessary and advisable in the treatment of the above named patient.

Assignment of Benefits: I hereby assign all Physical Therapy benefits, to include major medical benefits to which I am entitled to AUM Physical Therapy & Yoga Center, Inc. (APTYC). I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical/automobile med pay plan, or my attorney to issue payment check(s) directly to APTYC for Physical Therapy services rendered to me and/or my dependents regardless of my insurance benefits, if any. **I understand that I am fully responsible for: (i) knowing my insurance benefits for Physical Therapy, (ii) all co-payments, deductible balances and any charges not covered by insurance at the time of service.** All information gathered by APTYC is a courtesy. In the event the insurance company issues payment to me, for services rendered, I agree not to cash any insurance checks and will endorse the payment to APTYC, to represent payment for treatment I have received.

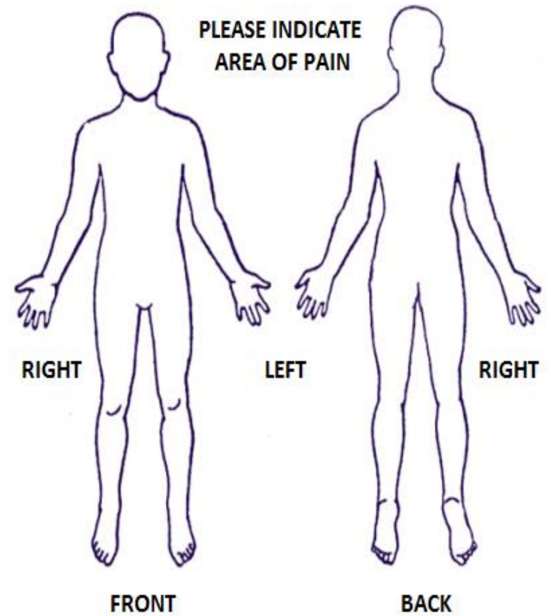
Medical Lien: I hereby direct my attorney, if applicable, to pay directly to APTYC any sums as may be due for Physical Therapy services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate APTYC. I hereby further give a lien on my case to said practice against any and all proceeds of my settlement, judgment, or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection therewith.

X ______________________________ ____________

Patient/ Legal Guardian Signature **Date**

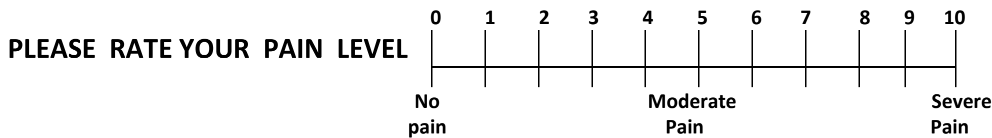
PLEASE PROVIDE YOUR MEDICAL HISTORY BELOW:

DIABETES	YES	NO	ARE YOU PREGNANT?	YES	NO
HIGH BLOOD PRESSURE . .	YES	NO	ALLERGIES	YES	NO
STROKE	YES	NO	SINUS ALLERGY	YES	NO
HEART ATTACK	YES	NO	PREVIOUS SURGERY.	YES	NO
HEART SURGERY	YES	NO	JOINT REPLACEMENT	YES	NO
PACEMAKER	YES	NO	METAL IMPLANTS.	YES	NO
HEADACHES	YES	NO	CANCER	YES	NO
MIGRAINES	YES	NO	ARTHRITIS	YES	NO
NERVOUSNESS	YES	NO	RHEUMATOID ARTHRITIS. . .	YES	NO
ANXIETY	YES	NO	GOUT	YES	NO
DEPRESSION	YES	NO	OSTEOPOROSIS	YES	NO
SEIZURES	YES	NO	SENSITIVE HEAT / ICE.	YES	NO
FIBROMYALGIA	YES	NO	SLEEPING PROBLEMS.	YES	NO
LUPUS	YES	NO	TMJ / JAW PAIN.	YES	NO
ASTHMA	YES	NO	SINUS PROBLEMS	YES	NO
COPD	YES	NO	NEUROPATHY	YES	NO
HERNIA	YES	NO	PSYCHIATRIC CARE	YES	NO
VISION PROBLEMS	YES	NO	VARICOSE VEINS	YES	NO
VERTIGO	YES	NO	KIDNEY PROBLEMS	YES	NO
CONSTIPATION	YES	NO	AUTO ACCIDENTS	YES	NO
ULCERS	YES	NO	HYSTERECTOMY	YES	NO



If YES to any of the above, please explain and give approximate dates: ______________________________

PLEASE RATE YOUR PAIN LEVEL



Are you currently taking any medication? Yes ☐ No ☐ If YES, please list all medications and for what condition:

Have you had Physical Therapy/ Occupational Therapy/ Speech Therapy / Chiropractic /Home Health services for this or any other condition within the last 12 months?

Yes ☐ No ☐ If YES, please provide details of when (approx. dates), where and total number of visits

Notice of Privacy Practices:

I certify that I have received information about the Notice of Privacy Practices from AUM Physical Therapy & Yoga Center, Inc. regarding the HIPAA rules which became effective April 13, 2003.

The above information is correct to the best of my knowledge.

X ______________________________ ______________________________

Patient/Legal Guardian Signature **Date**