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

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

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Name Address Number and Street Cry State Zip Phone	PATIENT INFORM	ATION								
Address Number and Street City State Zo Priore	Last		First	Middle Initial	Marital Status	Sex	Age	Date of Birth	Social Security Number	
Number and Street City State Cell Phone: Name of Employer	Name									
Insurance Coverage? Yes No E-Mail Address: Cell Phone: Name of Employer Employer's Address Number and Street City State Zija Phone				011						
Name of Employer's Address Number and Street City State Zip Phone Occupation How Long Employed? If Not Employed, Source of Income: Spouse's Name Coccupation 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 Name of Insurance: Name of Insurance Name of		_	No 🗖	·				•	Phone	
Occupation	Name of Employer							-		
Occupation	Employer's Address	Number and Sti	reet	C	itv		State	Zip	Phone	
Spouse's Name Occupation Date of Birth: Social Security # Employer's Name and Address Number and Street Oity State/Zip Phone If Student; Name of School Nearest Relative / Friend (Not living in the home) Name Relationship Primary Insurance: Name of Insurance Name of Insurance Secondary Insurance: Name of Insurance Name of Insurance Name of Insurance AUTO ACCIDENT / PERSONAL INJURY INFORMATION On the Job Traffic Accident At School At Home Other Insured Name: Claim Number: Aliuster Date of Injury: Do you have an attorney for this case? Yes No Attorney Name: AUTHORIZATION FOR MEDICAL TREATMENT / ASSIGNMENT OF BENEFITS / MEDICAL LIEN Authorization for Medical Treatment: 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, (ii) all co-payments, deductible balances and any charges not covered by insurance	Occupation				•					
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Employer's Name and Address Number and Street City State / City Phone										
Number and Street City State/Zip Phone Number and Street City State/Zip Phone Name of Insurance Information Primary Insurance: Name of Insurance Name of Insurance Name of Insurance Insurance Carrier: Insurance Address: Adjuster Date of Injury: Do you have an attorney for this case? Attorney Name: Authorization for Medical Treatment: In 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. to APTYC for Physical Therapy services rendered to me and/or my dependents regardless of 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	·			Date of Birth:		500	ial Securit	y #		
Nearest Relative / Friend (Not living in the home) Name Relationship Phone	Employer's Name and	Address _		Numbe	r and Street	(City	State/Zip	Phone	
INSURANCE INFORMATION Primary Insurance: Name of Insurance Name of Insurance AUTO ACCIDENT / PERSONAL INJURY INFORMATION On the Job Traffic Accident At School At Home Other Insured Name: Claim Number: Adjuster Date of Injury: Do you have an attorney for this case? Yes No Attorney Name: AUTHORIZATION FOR MEDICAL TREATMENT / ASSIGNMENT OF BENEFITS / MEDICAL LIEN Authorization for Medical 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	If Student; Name of So	chool								
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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	Physical Therapy & Yo and any other health, services rendered to removing my insurance at the time of services rendered, I a have received. Medical Lien: I hereby	oga Center, In/medical/autome and/or my e benefits foe. All informagree not to condition with the condition of the condition	nc. (APTYC). I omobile med dependents r Physical Th ation gathere ash any insur	hereby authorize and pay plan, or my atto regardless of my insuerapy, (ii) all co-payned by APTYC is a courrance checks and will plicable, to pay direct	d direct my insommer to issue por ance benefits, nents, deduction tesy. In the even endorse the party to APTYC any	urance ca ayment cl if any. I oble balance ent the ir yment to	rrier(s), in neck(s) di understar es and an isurance o APTYC, to may be du	cluding Medica rectly to APTYC od that I am full y charges not of company issues o represent pay the for Physical T	re, private insurance for Physical Therapy ly responsible for: (i) covered by insurance apayment to me, for ment for treatment I	

Patient/Legal Guardian Signature

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Date

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.

PLEASE PROVIDE YOUR MEDICAL HISTORY BELOW:									
DIABETES Y	ES NO	ARE YOU PREGNANT?	YES	NO					
HIGH BLOOD PRESSURE Y	ES NO	ALLERGIES	YES	NO					
STROKE Y	ES NO	SINUS ALLERGY	YES	NO	PLEASE INDICATE				
HEART ATTACK Y	ES NO	PREVIOUS SURGERY	YES	NO	AREA OF PAIN				
HEART SURGERY Y	ES NO	JOINT REPLACEMENT	YES	NO					
PACEMAKER Y	ES NO	METAL IMPLANTS	YES	NO					
HEADACHES Y	ES NO	CANCER	YES	NO					
MIGRAINES Y	ES NO	ARTHRITIS	YES	NO					
NERVOUSNESS Y	ES NO	RHEUMATOID ARTHRITIS	YES	NO					
ANXIETY Y	ES NO	GOUT	YES	NO	51 17 51 1				
DEPRESSION Y	ES NO	OSTEOPOROSIS	YES	NO	not I has an I has				
SEIZURES Y	ES NO	SENSITIVE HEAT / ICE	YES	NO	RIGHT \				
FIBROMYALGIA Y	ES NO	SLEEPING PROBLEMS	YES	NO					
LUPUS Y	ES NO	TMJ / JAW PAIN	YES	NO					
ASTHMA Y	ES NO	SINUS PROBLEMS	YES	NO					
COPD	ES NO	NEUROPATHY	YES	NO	11 11 11				
HERNIA Y	ES NO	PSYCHIATRIC CARE	YES	NO					
VISION PROBLEMS Y	ES NO	VARICOSE VEINS	YES	NO	A A				
VERTIGO Y	ES NO	KIDNEY PROBLEMS	YES	NO	FRONT BACK				
CONSTIPATION YI	ES NO	AUTO ACCIDENTS	YES	NO					
ULCERS YI	ES NO	HYSTERECTOMY	YES	NO					
PLEASE RATE YOUR PAIN L	o FVFI	1 2 3 4 5 6 7	8	9 1	0				
PLEASE NATE TOOK PAIN E			+						
	No pain	Moderate Pain		Se ₁ Pai	vere in				
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									
In 125, picase provide actains of which (approx. dates), where and total humber 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.									
•			/ Prac	tices fr	rom AUM Physical Therapy & Yoga Center, Inc.				
•	nich beca	me effective April 13, 2003.	/ Prac	tices fr	rom AUM Physical Therapy & Yoga Center, Inc.				
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