OrthoSport Physical Therapy & Athletic Rehabilitation
PATIENT INFORMATION

DATE ____________________

Last Name __________________________ First ___________________________M.I._______

Preferred/Nickname __________________

Address ____Apt# ________________

City _____________________________________ State ________ Zip ________________

Home ph:______________________________Work:___________________________________

Cell:________________________________ Date of Birth: ________________ Age: ________

Email: _______________________________________ Sex: M __F __

Employed________Full Time Student _______Retired _______

Employers Name/Address/Phone: ____

____

Emergency Contact Person: ____

Relation to You: ___________Phone _______________________ Cell ______________________

Is this an auto related injury? Yes _____ No _____
Is this a work related injury? Yes _____ No _____
If work related, who is your employer? ____
SS# if we are billing Workers Compensation or Auto:_______________________________________
Do you have a pacemaker: Yes _____ No _____

Date of Injury: _____________________ and/or Date of Surgery: ________________________

Referring Doctor: ____

NOTICE OF PRIVACY PRACTICES

I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES.

AUTHORIZATION TO PAY FOR ANY PHYSICAL THERAPY

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to OrthoSport Physical Therapy & Athletic Rehabilitation and I am financially responsible for non-covered services. I also authorize OrthoSport Physical Therapy & Athletic Rehabilitation to release any information to process this claim.

SIGNED: ____

(If patient is a minor, a parent or guardian will need to sign on their behalf.)