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: _____

Sex: M __F __ SS# _____
(Include social security if you are filing a Worker's Comp or Auto related claim.)

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? _____

Do you have a pacemaker: Yes - No

Date of Injury: _____ 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.)