



Patient Registration Form - Please Print

New Patient? Yes No

Today's Date: _____

How did you find our clinic: Physician Relative/Friend Internet Other: _____

Patient Information

Name: Last First Middle

Address: _____

City/ State/ Zip: _____ Email (optional): _____

Phone: Home Work Mobile

Birthdate: Age: Sex: Male Female

Date of Injury/ Onset Date: Diagnosis: _____

Medicare: Yes No If yes, have you received PT/ Speech services since 1/1/2008? Yes No
Auto Related: Yes No If yes, Adjustor Name: Phone #:
Work Related: Yes No If yes, was it with current employer? Yes No Case Worker Name and Phone#:

Primary Insurance Information

Name of Insurance Company: Phone#: _____

Policy#: Group/Plan#: _____

Policy Holder Name: Date of Birth: SSN# - -

Policy Holder's Employer: Patient relationship to Policy Holder: Self Spouse Dependent Other

Employer Information

Employer Name: Employer Phone #: _____

Employer's Address: City/State/Zip: _____

Occupation: Employment Status: FT PT Self-Emp Retired Other

Physician Information

Name of Physician: Phone#: Fax#

Physician Address: City/State/Zip: _____

Emergency Contact Information

Contact Name: Home Phone#: Cell#: _____

Relationship to Patient: Parent Spouse Sibling Other _____



I hereby authorize Elite Sports Physical Therapy through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring Physician.

I further authorize Elite Sports Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Signature

Date

Relationship To Patient