|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SPORTS & ORTHOPEDIC SPECIALISTS**  **PATIENT REGISRATION FORM** | | | | |  | |
| **PATIENT NAME** | | | | | | |
| Last: | | First: | | | | DOB: |
| **PATIENT ADDRESS** | | | | | | |
| Street: | | City: | State and Zip Code: | | | |
| **PATIENT CONTACT INFORMATION** | | | | | | |
| Email Address: | | | | | | |
| Home phone: | | Cellular or other: | | | | |
| **NAME OF RESPONSIBLE PARTY IF OTHER THAN PATIENT**. | | | | | | |
| Last: | | First: | | | | DOB: |
| **ADDRESS OF RESPONSIBLE PARTY** | | | | | | |
| Street: | | City: | State and Zip Code: | | | |
| **CONTACT INFORMATION OF RESPONSIBLE PARTY** | | | | | | |
| Email Address: | | | | | | |
| Home phone: | | Cellular or other: | | | | |
| **MEDICAL INFORMATION** | | | | | | |
| Primary Diagnosis/Treatment Area | Secondary Diagnosis/Treatment Area | | | | | DOI |
| **REFERRING PHYSICIAN INFORMATION**  California is a Direct Access state for physical therapy services. We are able to treat patients without a physician’s diagnosis for 12 visits or 45 days, whichever comes first.  After that, we will need proof of a physician’s diagnosis with date and physician’s signature.  Medicare and most private insurance require a physician prescription for all treatment. | | | | | | |
| Physician Name: | | | | Rx Frequency/Duration/Visits: | | |
| **I certify that the above information is correct to the best of my knowledge.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient Signature (Parent or Guardian if Minor) Date** | | | | | | |