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| **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**  |