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**