ESPT

Elite Sports Physical Therapy

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: _____

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 1/1/2013? □ Yes □ No
Have you exceeded your Medicare Cap? □ Yes □ No, Amt Used-$_____

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#_____-____-_____

Patient relationship to Policy Holder:

Policy Holder's Employer: _____ □ 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 _____

ESPT

Elite Sports Physical Therapy

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