

**PATIENT INFORMATION**

 Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ SS #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

 Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ □ Male □ Female Marital Status: □ Single □ Married □ Widowed □ Other

 Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: □ English □ Spanish □ Other \_\_\_\_\_\_\_\_\_\_\_

 Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check box if mailing address is same as above: □

 Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

 Preferred Contact #: □ Cell □ Home □ Work Are you a Veteran? : □ Yes □No

 Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF PATIENT IS A MINOR OR HAS A GUARDIAN**

 Person responsible for scheduling and payment: □ Guardian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medical Power of Attorney on file: □ No □ Yes *If Yes, please provide a copy*

 Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: □ Parent □ Guardian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Responsible Party’s Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Responsible Party’s Driver License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Responsible Party’s SS #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Responsible Party’s Contact #: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

 Responsible Party’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

 In case of emergency, contact (not living with you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Is your medical condition due to a work related injury? □ No □ Yes If yes, what is the date of injury? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

 Referring Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Therapist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist’s Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

 Do you have allergies to any contact materials? □ No □ Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Height \_\_\_Ft.\_\_\_In. Weight \_\_\_\_\_\_lbs.

 Rev. 2022

Internal use – received/reviewed by: \_\_\_\_\_\_\_\_

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