

**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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