EDGE Physical Therapy & Sports Medicine

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| Required Patient Information | | |
| Name (First, Last) | | Home Address |
| Date of Birth | |
|  | |
| Gender (circle) Male Female | | Home Phone |
| Marital Status (circle) Single Married Other | | Mobile Phone |
| How did you find out about us? (circle) Doctor Family Friend Internet Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Have you had treatment (speech or physical therapy) within the current year? Yes No | | |
| If yes, was it in an in-patient office or out-patient office? | | |
| EMERGENCY CONTACT INFORMATION | | |
| Name | Home Phone | |
| Relationship to you | Mobile Phone | |
| EMPLOYMENT INFORMATION | | |
| Employment Status (circle) Full-Time Part-Time Unemployed Retired | | |
| Disability Status, if applicable (circle) Temporary/Short-Term Permanent/Long-Term | | |
| Employer Name | Employer Address | |
| Work Phone |
| Occupation |
| DOCTOR and INURY INFORMATION | | |
| Referring Physician | Referring MD Phone Number | |
| Date of last visit to Referring MD | Referring MD Office (City/Town) | |
| Primary Care Physician | PCP Phone Number | |
| Date of last Visit to PCP | PCP Office (City/Town) | |
| Date of Injury | Date of Surgery, if applicable | |

I, (PRINT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize EDGE Physical Therapy to treat me as per my doctor’s prescription and to release my insurance company/lawyer/employer any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_