EDGE Physical Therapy & Sports Medicine

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| Required Patient Information  |
| Name (First, Last)  | Home Address   |
| Date of Birth  |
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| 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_