PENINSULA
SPORTS MEDICINE

PATIENT REGISTRATION INFORMATION

Patient's Name: _____ Male/Female
(First) (M) (Last)

Address:_____
Street City State Zip

Home #: (____) _____-_____ Cell #: (____) _____-_____ Work #: (____) _____-_____

Email address _____

Date of Birth: _____/_____/_____

Name of Employer
at time of injury: _____ Current Employer _____ Phone#: _____

Address:

_____
Street City State Zip

Emergency Contact: _____ Telephone #: (____) _____-_____ Relationship: _____

I have reviewed the information contained on this form and certify that it is true and accurate to the best of my knowledge. **I understand I am financially responsible for all non-insured goods and services.** I authorize PSMRC to release medical information and assign my insurance benefits to be paid directly to PSMRC for physical therapy related expenses incurred while in their care. **The balance is my responsibility whether the insurance pays or not**. My signature authorizes physical therapy treatment at PSMRC, including its inherent risks, and authorizes medical records to be released to PSMRC.

_____ _____
SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE