GENERAL INFORMATION

PATIENT NAME ____ TODAY'S DATE _____/_____ /_____
ADDRESS ____ DATE OF BIRTH _____/_____ /______
CITY ____
STATE ______ZIP _________ Male or Female
HOME PH# (______) __________________________
CELL PH# (______) ___________________________
WORK PH# (______) ________________x_______ Single Married Divorced
EMAIL ____ Widowed Other
If patient is a minor, PARENT OR GUARDIAN NAME(S):
____
Who is your family physician? ____
Would you like us to send him/her an update? **Y N**

EMERGENCY CONTACT

NAME ____ RELATIONSHIP__________________________
ADDRESS ____
CITY ____ STATE_______ ZIP ___________
HOME PH# (______) _____________________________ CELL PH# (______) ________________________
WORK PH# (______) _____________________x_______

AUTHORIZATIONS (Initial all lines that are appropriate.)

______ I authorize Kinetic Edge Physical Therapy to provide me, or the patient for whom I am legally responsible, medical treatment.
______ I authorize Kinetic Edge Physical Therapy to contact me via phone, mail or email regarding issues related to my treatment.
______ I understand that Kinetic Edge Physical Therapy adheres to the HIPAA policy and I understand that my personal information will be kept confidential.*
______ I authorize Kinetic Edge Physical Therapy to send me appointment reminders. Select which method you would like reminders: _____ Text _____ E-mail
______ I authorize Kinetic Edge Physical Therapy to send my patient statement through a secure email link or e-statement to the email address above.
______ I authorize Kinetic Edge Physical Therapy to disclose information regarding my injury, as well as my general fitness to play, to my coaches or teachers as needed for safe sport or class participation.*
______ I authorize Kinetic Edge Physical Therapy to disclose information to the following individuals:
Name: ______________________________ Relationship: _________________ Ph #: ______________
Name: ______________________________ Relationship: _________________ Ph #: ______________
*Refusing to initial will not prevent you from receiving treatment.

____ _______________
Signature of Patient or Authorized Person Date