CONSULT / INJURY CONSULT
PATIENT CONTACT INFO & RELEASE

Sports & Physical Therapy

Date: _____

PERSONAL INFORMATION

Legal Name _____ Nickname _____
First Middle Initial Last

Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Age _____ Date of Birth _____ SSN _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Appointment Reminders ☐ Email ☐ Text ☐ Voice If text or voice, which number? _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Spouse Name _____ Phone Number _____

☐ Minor - Parent(s) Name(s) _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Emergency Contact Relationship to Patient _____

COACH / TRAINER INFORMATION

Coach/Trainer Name _____ Phone Number _____

MEDICAL HISTORY

Date of Injury _____ Primary Care Physician _____

FINANCIAL / RELEASE INFORMATION

Charges, if applicable, for this treatment and any supplies dispensed are due and payable at the time of treatment unless prior arrangements have been made.

Medical Release: I authorize Rebound Sports & Physical Therapy to release information from my file to my coaches, trainers, employer, or doctors as needed.

I certify that I have reviewed and understand the above information supplied by me and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures, patient care, and therapy supplies, which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Rebound Sports & Physical Therapy.

Patient/Guardian Signature _____ **Date** _____