Connections Physical Therapy, LLC

New Patient Information Sheet

Welcome! Please help us serve you better by taking a few minutes to provide the following information.

Patient's Full Name: _____

Patient's Nick Name: _____**Occupation:** _____

Address: _____

_____

City _____**State** _____ **Zip Code**_____

Home Phone: _____

Cell Phone: _____

EMAIL ADDRESS: _____

Please circle your preferred method of contact: home cell e-mail

Date of Birth: _____ **Age:** _____ **Sex:** (M, F) _____

Referring Doctor's full name: _____

Emergency contact's name: _____ **phone:** _____

Name of Parent or Guardian: (if patient is under 18): _____

Parent or Guardian's phone: _____ **Relationship to patient:** _____

How did you hear about us? (Please circle) Doctor Internet Friend Brochure Other _____

I attest that the information listed above is accurate and that I can be contacted regarding my treatment at the above phone numbers (including voice mail and text), e-mail address and mailing address unless otherwise specified. I am aware that using unencrypted e-mail and texting may not be secure. My signature authorizes this practice to release my medical records to my referring physician.

_____ _____

Signature of patient (or parent/ guardian) Date