SPORTS MEDICINE AND REHABILITATION THERAPY, INC.

PHYSICAL THERAPY

www.smartphysicaltherapy.com

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781-944-5246
FAX: 781-944-6686

PLEASE PRINT AND SUPPLY ALL INFORMATION

Name:_____ **DOB**____/____/____

Address:_____ **City/State/Zip** _____

Home: (____) _____ - _____ **Cell:** (____) _____ - _____ **SSN*** _____ - _____ - _____

Employer: _____ **Phone:** (____) _____ - _____ - _____

Occupation: _____

Emergency Contact:_____ **Phone:** (____) _____ - _____ - _____

Insurance Company:_____ **City/State/Zip** _____

Subscriber:_____ **SSN*** _____ - _____ - _____

Relationship to Patient:_____ self _____ spouse _____ parent/legal guardian

Date of injury _____ **Is your injury** Work related? _____ Mva? _____

*SSN required for office credit protection use only

HEALTH INSURANCE PORTIBILITY & ACCOUNTABILITY ACT ("HIPAA") NOTICE OF INFORMATION PRACTICES

FEDERAL LAW REQUIRES THAT YOU BE AWARE OF HOW WE MAY USE YOUR MEDICAL INFORMATION. A COPY OF THESE REGULATIONS ARE AVAILABLE TO YOU AT OUR FRONT DESK.

I acknowledge being offered a copy of this notice:

_____ Date: _____

Signature of Patient or Parent/Legal Guardian