COREssentials
PHYSICAL THERAPY AND PELVIC WELLNESS, PLLC

Patient Registration

Patient Name:_____ Social Security #:_____

Date of Birth:_____ Age:_____ Date of Surgery/Injury:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

E-mail:_____

Referring Physician:_____ Primary Care Physician:_____

Referring Physician Phone: _____ Referring Physician Fax: _____

Emergency Contact: _____

Emergency Contact Phone:_____ Relationship:_____

Is your injury/condition due to a car accident? Y N Receiving Home Health? Y N

Appointment Reminder Option (Check One): _____ Call _____ Text Message

Authorization to Release Protected Health Information during this Admission

Information about your health and health care treatment is filed in your medical record. This information is confidential. You control how the clinic releases this information during your care. Please **SELECT ONE** of the following regarding how you wish to have information regarding your health and health care treatment released.

Privacy Code Choice A **Initial:_____**

I authorize the clinic to release the following:

1. Anyone who asks may be told I am in the clinic.
2. My immediate family (which includes, husband/wife, parent, and child) may be told my diagnosis, medical history, treatment, and prognosis.

Privacy Code Choice B **Initial:_____**

1. No one may be told I am in the clinic.
2. No one may be told my diagnosis, medical history, treatment, or prognosis.

Print Name of Patient

_____

Signature of Patient/Patient Representative

_____

Patient's DOB

_____

Date _____