Functionize Health & Physical Therapy

Patient Contact Information **Today's Date_____**

Personal Information

Full Name: _____
Last *First* *Preferred Pronoun(s)*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Email _____

Occupation _____

Employer/Work Address _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Primary Care Provider

Name of Physician: _____ Phone Number: _____

Practice: _____

Georgia Law and the State of Georgia Physical Therapy Board requires patients to have a written referral from a licensed medical practitioner (MD, DO, DDS, DPM, NP, PA) after 21 days of care or to receive Intramuscular Manual Therapy Treatment (i.e., trigger point dry needling). It is your responsibility to obtain and maintain a current referral prior to your evaluation and during your treatments. If you do not have a current provider, we can assist you in finding highly qualified practitioners in your area.

I authorize *Functionize Health & Physical Therapy* to release all medical information and/or records to my requesting insurance company and/or referring physician.

X _____

Signature of Patient/Guardian and Date