VPTR – PATIENT INFORMATION

Date: ____/____/____

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

Address:_____
_____
City:_____
State:_____ ZIP:_____
Marital Status: S M D W

Home phone: ( )_____
Cell #: ( )_____
Date of Birth:_____/_____/_____ Age:_____
S.S.#:_____/_____/_____

EMERGENCY CONTACT:
Name:_____
Relationship:_____
Phone:_____

Referring Doctor:_____
Family Doctor:_____
Next Doctor's visit:_____

How did you become aware of Vantage Physical Therapy and Rehabilitation (check)?

❑ Doctor ❑ TV ❑ Newspaper ❑ Radio ❑ Internet ❑ Phone Book
❑ Family/Friend ❑ Billboard ❑ Sports program ❑ Other (list):_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Vantage Physical Therapy and Rehabilitation reserves the right to modify their privacy practices outlined.

Whom may we release information to regarding your care?

NAME	PHONE NUMBER	RELATIONSHIP

❑ I have **RECEIVED** a copy of the Notice of Privacy Practices for Vantage Physical Therapy and Rehabilitation.
❑ I have **DECLINED** a copy of the Notice of Privacy Practices for Vantage Physical Therapy and Rehabilitation.

I am aware of my medical condition for which I am seeking professional services from **Vantage Physical Therapy and Rehabilitation, P.C.** I permit all **VPTR** employees to work with and direct me towards medical recovery but understand no guarantees can be made. I authorize **VPTR** to release any pertinent information regarding my care at **VPTR** to my physician, dentist, or podiatrist; or to my insurance carriers. Any other sources will require a separate release form signed by me.

_____ _____ _____
PATIENT SIGNATURE PRINT NAME DATE

If patient is a minor or an adult who is unable to sign, please sign and print below.

_____ _____ _____
PATIENT REPRESENTATIVE SIGNATURE PRINT NAME DATE

_____
RELATIONSHIP TO PATIENT

_____ _____
VPTR REPRESENTATIVE SIGNATURE DATE