



PHYSICAL THERAPY AND SPORTS MEDICINE CENTER
9340 Fuerte Drive, Suite 303A
La Mesa, CA 91941

PATIENT INFORMATION

Legal Name _____ Preferred Name _____

Address _____

City _____ State _____ Zip _____

Landline (____) _____ Cell (____) _____ Work (____) _____

Email _____

Date of Birth _____ Age _____ Gender Identity _____ Marital Status _____

Social Security # _____ Driver's License & State _____

Physician's Name _____ Phone (____) _____

Emergency Contact _____ Relationship _____

Cell (____) _____ Work (____) _____

Spouse's name _____ Phone (____) _____

Employer _____ Occupation _____

Address, City, State, Zip _____

Date of Injury or Onset _____ Area of body to treat _____

Was Injury: Work related _____ Auto Accident _____ Other _____

I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits directly to Physical Therapy and Sports Medicine Center for services rendered to me. I understand that unless other arrangements have been made, all charges are due and payable at the time services are rendered.

Patient/Guardian Signature _____ Date _____