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sportsandperformancept.com

Patient Intake Form

Demographic Information:

Full Name (as it appears on your insurance card)

Preferred Name/Nickname

Street Address City, State Zip Code

Phone # Home Mobile

Email address: we will use for sending home exercise program and clinic info

Phone# Home Mobile

Date of Birth

Age

Gender

Appointment Confirmation Preferred Method: Phone Call Text Message Email No reminders please

Employer

Occupation

Working: Yes/no/modified

Emergency Contact

Relationship

Phone

Insurance Information:

Insurance Carrier

Responsible Party

If responsible party is other than self, Primary Subscribers Name and Date of Birth

Responsible Party's Phone #

Secondary Insurance Carrier Subscribers Name and Date of Birth

Responsible Party

Referring Physician:

Name of Referring Physician

Physician Phone #

Date of next visit with referring physician

Primary Care Physician

Primary Care Phone #

How did you hear about Sports & Performance Physical Therapy?

(Please Specify, so we can say "Thank you")

Physician former patient sports team/coach dance school/instructor internet (Yelp/Web) Other

Patient or Guardian Signature

Date