Sprint Sports Rehabilitation, Inc.
11 E. College Blvd.
Roswell, NM 88201-5158
575-622-6500 Phone 575-622-9777 Fax

All questions must be answered

Patient Name: ____________________________ Sex: ____ SSN: ____________________

Date of Birth: _________Driver's License: ______________ Email: __________________

Home Mailing Address: ____
City: ______________________ State: ______________________Zip Code: _________

Home Phone: ______________________ Cell Phone: ____________________________

Emergency Contact Name: _____________________ Phone: ______________________

Marital Status: ____ Spouse or Parent Name:_________________ Phone: ____________

Student?: ☐ Yes ☐ No Employed?: ☐ Yes ☐ No Employer/School Name: ____________

Employer/School Address: __________________ Employer Phone: _________________

Referred by: _________________ Primary Care Provider: __________________________

Did you have surgery? ☐ Yes ☐ No If so, date of surgery: ________________________

Work Related? ☐ Yes ☐ No Accident Related?: ☐ Yes ☐ No Date of Injury: ___________

Primary Insurance Company or Worker's Compensation Name: _____________________

Guarantor's Name: __________________Date of Birth: _________ SSN: ____________

Guarantor's Address: ___________________________________ Phone: _____________

Policy Number: _______________ Group Number: _________ Employer: __________

Secondary Insurance Company: _______________ Insured's Name: _________________

Policy Number: _______________ Group Number: _________ Employer: __________

Guarantor's Name: __________________Date of Birth: _________ SSN: ____________

Guarantor's Address: ___________________________________ Phone: _____________

Have you executed an advance directive or living will? ☐ Yes ☐ No

Have you had physical therapy before? ☐ Yes ☐ No If so, when? ________________

Are you currently receiving home health? ☐ Yes ☐ No Date of discharge: _________
If you are, physical therapy may not be covered in outpatient patient setting and you will be responsible.

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list: _____________

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Do you have any health problems, illness or condition which could effect your treatment such as allergies, heart disease, seizures, pregnancy, pace maker, history of cancer, etc?: ☐ Yes ☐ No If yes, please circle or list other: ____________________

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Please Describe any exercise, sports or recreational activities you are interested in: ______

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Medical authorization and acknowledgement of receipt of notice of privacy practices

I have read and was offered a copy of the HIPPA notice of privacy practices for Sprint Sports Rehabilitation, Inc. and understand my signature may be used for treatment, release of information to my referring healthcare providers, law enforcement, insurance companies, health care operations, public health reporting, attorneys involved in my case and collection companies for unpaid bills. I also acknowledge I am ultimately responsible for my bill and obtaining insurance benefits and coverage for my care received at Sprint Sports Rehabilitation, Inc.

I will be responsible for interest on unpaid bills and the following fees: $25.00 charge for returned checks and cancellations or no shows without 24 hours notice.

________________________	________________________	____________
Signature of Patient	*Printed Name*	*Date*
________________________	________________________	____________
Signature of Guardian If Minor	*Printed Name*	*Date*