Patient Registration Form

First Name _____ **MI** ___ **Last Name** _____

Date of Birth _____ **Gender** ☐ **Male** ☐ **Female**

Mailing Address _____

_____

_____

_____

Physical Address _____
(if different from above) _____

County: _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

Cardin & Miller PT, PC may contact you via phone or email for informational and educational services.

Emergency Contact Name _____

Emergency Contact Number _____

Were you referred by a Physician for today's appointment? ☐ **Yes or** ☐ **No** _____
Name of Physician

What is the name of your Family Doctor? _____

What is the name of your Endocrinologist? _____

What is the name of your Podiatrist? _____

Have you had Speech, Occupational, Home Health or Chiropractic care this year? ☐ **Yes or** ☐ **No**

If Yes, Please Explain: _____

How did you hear about us?
(please choose one)

☐ **Facebook**
☐ **Friend/Word of Mouth** _____ **(name of friend)**
☐ **Employer/Case Manager**
☐ **Marketing Email**
☐ **Newspaper**
☐ **Hospital/Walk-in Clinic**
☐ **Marketing Mailer**
☐ **Previous Patient**
☐ **Physician**
☐ **Marketing Newsletter**
☐ **Website**
☐ **Other:** _____

By signing this form, I hereby acknowledge that all the information is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient **Date**

Thank you for choosing Cardin & Miller Physical Therapy to aide you in your healthcare needs!