

CONLEY REHABILITATION & SPORTS MEDICINE

REGISTRATION FORM

Last name: _____ First name: _____ MI: _____

Social security: _____ Date of birth: _____ Sex: _____

Street address: _____

City: _____ Zip: _____ State: _____

Home phone number: _____ Cell phone (optional): _____

Marital status (place a X): Married: _____ Single: _____ Other: _____

Employment status (place a X): Employed: _____ Retired: _____ Student: _____

Employer/school: _____

Work address: _____

City: _____ Zip: _____ State: _____

Work phone number: _____

Reason for today's visit: _____ Referring physician: _____

Body part/injury/or condition: _____

Date of injury or date symptoms began to occur: _____

Is this a work related injury? _____ If yes, claim number: _____

Is this a car accident injury? _____ If yes, list below who will be financially responsible

_____ Claim number: _____

Is an attorney involved in your case? _____ Phone number: _____

I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF BURKAM & ASSOCIATES AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

_____ Patient's Signature _____ Date
Legal Guardian if not 18 yrs old