



DANCE, ORTHOPEDIC & SPORTS PHYSICAL THERAPY

130 West 56<sup>th</sup> Street, Suite 6M, New York, NY 10019

T 212.246.3700 F 212.246.3701

**Registration Information:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve): \_\_\_\_\_ Phone (Cell): \_\_\_\_\_

May We Leave Messages at the Numbers Listed Above When We Need to Contact You? Yes / No

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Person We Should Contact in Case of Emergency: \_\_\_\_\_

Phone Number and Relationship: \_\_\_\_\_

How did you find out about PT Plus, P.C.? \_\_\_\_\_

**What are your current concerns or chief complaints?**

Describe the problem(s) that have brought you here today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consent for Treatment:**

My signature below authorizes PT Plus, P.C., and its Physical Therapy and Certified Athletic Trainer staff to evaluate me and provide general health recommendations as they reflect the reasonable, objective practices of the health care profession.

I understand that I may ask questions at any time and that I may elect not to participate in the recommended made, at my sole discretion.

Signature of Patient or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_