

# Sport Summit Physical Therapy

## Student Athlete Information

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

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred name/nickname: \_\_\_\_\_

Name of parent or legal guardian: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: M: \_\_\_\_\_ F: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

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

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Past medical history / Past surgical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### NOTICE OF PRIVACY PRACTICES

I have been provided an opportunity to review the notice of privacy practices.

### AUTHORIZATIONS

- I hereby give Sport Summit Physical Therapy permission to provide treatment using their professional judgement and reasoning.
- I certify that the information provided is true and current to the best of my knowledge. I will notify you of any changes in my health or the above provided information.
- I acknowledge and understand that there is no cost or fee for the treatment / consultation provided by Sport Summit Physical Therapy under this agreement.

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_