MR# _____

Welcome To TMI Sports Medicine & Orthopedics

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Email Address: _____ May send information to? Yes / No
Occupation: _____ SSN: _____
Employer: _____ Dept.: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsibility Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Dept.: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Dept.: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In case of an emergency, contact: _____Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____
How did you learn about our practice? _____

I hereby authorize employees and agents; including physicians, physician assistants, medical assistants, physical therapist, athletic trainers or physical therapy techs of this medical office to render routine medical care to the patient indicated on this form.

_____ _____
Date Patient Signature
(if patient is under 18, legal guardian signature)