PATIENT REGISTRATION FORM

PATIENT: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Please complete the following so that we may properly credit your school's athletic department:

School: _____ Sport: _____
School Address: _____City: _____Zip: _____

PARENT / LEGAL GUARDIAN CONTACT

☐ PT LIVES WITH

Parent:_____☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Relationship: ☐ Mother ☐ Father ☐ Other_____

S.S.: _____-_____-_____*Unknown / Refuse*

DOB:_____/_____/_____

Address:_____

City:_____**St:** _____ **Zip:**_____

Lang.: *English Spanish Russian Hindi* **Other:**_____

Home Email: _____

Employer: _____

Occupation:_____

Phone:_____**Work:**_____

Cell:_____

☐ PT LIVES WITH

Parent:_____☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Relationship: ☐ Mother ☐ Father ☐ Other_____

S.S.: _____-_____-_____*Unknown / Refuse*

DOB:_____/_____/_____

Address:_____

City:_____**St:** _____ **Zip:**_____

Lang.: *English Spanish Russian Hindi* **Other:**_____

Home Email: _____

Employer: _____

Occupation: _____

Phone:_____**Work:**_____

Cell:_____

PREFERRED CONTACT METHODS (*Circle One)*

Medical Issues: Home Phone Cell Phone Text Message Email
Reminders & Recalls: Email Text Message

Signature of responsible Parent / Legal Guardian **Date**

10085 Red Run Boulevard, Suite 201• Owings Mills, MD 21117 Telephone:410-363-1843 Fax: 410-363-3027