



**NORTH STAR**  
manual therapy

Specialized Sports and Physical Therapy

557 South IH-35, Suite 101 Georgetown, TX 78626  
(512)868-5488 Fax (512)868-5484

**Patient Contact Information**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ DOB \_\_\_\_\_  
Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_ Other \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail \_\_\_\_\_ S.S.# \_\_\_\_\_  
Employer \_\_\_\_\_ DL# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**Parent/Guardian/Spouse Name** \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Contact Phone \_\_\_\_\_

**Emergency Information/ Nearest Relative**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ SS# \_\_\_\_\_  
Contact Phone \_\_\_\_\_

**I/We authorize *North Star Manual Therapy, Inc* to release all medical information and/or records to my requesting insurance company and/or referring physician.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date