Patient Information Record

(Please completed entirely)

Date: ______________________

First: ___________________________ M.I.: ______ Last: _________________________________

Social Security Number: ___________-___________-___________

Date of Birth: ________-_______-_________ Age: __________ Sex: ___________

Home Address:____

City: ____ State: _________ Zip: _____________

Home Phone: (____) ________-_________ Cell Phone: (____) ________-_________

Work Phone: (____) ________-_________ Employer: ___________________________________

Email Address: _______________________ School/Occupation: ___________________________

Would you like to receive information, discounts, and promotions via email from either The Training Room or Velocity Sports Performance? Yes No

Emergency Contact: ________________________________ Phone: (____) ________-_________

Name of Spouse: ________________________ His/Her Employer: _________________________

Referring Physician: ____

Primary Care Physician:______________________________ Phone:________________________

Date of injury / date of onset: _____________ Is this the result of an accident? ______________

If yes, what type of accident? AUTO / WORK / OTHER: _________________________________

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _______________________________
And assign directly to The Training Room, LLC all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authoriz the use of my signature on all insurance submissions. The Training Room, LLC may use my health care information an may disclose such information to the above named insurance company(ies) and their agents for the purpose c obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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Signature of Patient, Parent, Guardian Date