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Cheryl Maurer PT, MS, C.Ped.
Doctoral Candidate

Patient Registration

First Name: Middle Name: Last Name:

Address 1: City: State: Zip code:

Address 2: City: State: Zip code:

Email:

Check box to make your required selection:

Work Phone: Ext: ☐ Use this as my primary phone number

Home Phone: ☐ Use this as my primary phone number

Cell Phone: ☐ Use this as my primary phone number

Fax:

I would like appointment reminders via ☐ email, ☐ text message or ☐ by phone.

Date of Birth: Age: Height: Weight: Shoe Size:

(Indicate if home, cell or work)

Emergency contact: Primary phone:

Secondary phone:

Relation:

(If different from above or emergency contact)

Legal Guardian: Primary phone:

Address (if different from above): Secondary phone:

Relation:

Signature of patient or legal guardian **Date**

Edited: 1/11/2013 11:36 AM