FYZICAL®
Therapy & Balance Centers

New Patient Registration Form

Patient Information

Name: _____ Date of Birth:_____

Home Phone #: _____ Work Phone #:_____

Mobile Phone #:_____ Gender:_____

Emergency Contact (Name and Phone): _____

Email: _____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip:_____

Marital Status: Single Married Other:_____

1. Is your injury related to any of the following?

Auto Related Work Related Other Accident None of These

IF you selected "Work Related" to (1) above, please provide employment information below.

Employment Status: Full-time Part-time Other:_____

Employer Name:_____

Employer Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

IF you selected "Auto Related" or "Work Related" to (1) above, please provide incident information below.

Insurance Company Name:_____

Claim #:_____ Date of Incident:_____

Case Manager Adjustor:_____

2. Is there an attorney involved with your injury?: Yes No

IF you selected "YES" to (2) above, please provide attorney information below.

Name:_____ Phone #:_____

3. How did you hear about us?

☐ Doctor Referral

☐ Friend/ Family

☐ Website /Internet

☐ I've had PT here before

☐ Direct Mail

☐ Other_____

Insurance Information

4. Are you currently receiving Home Health services, or have you received them in the past 60 days?: Yes No

IF you selected "Yes" to (4) above, please provide the agency information below.

Agency Name:_____

Date of Last Home Health Visit:_____

5. Are you a Medicare patient? Yes No

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IF you selected "Yes" to (5) above, please provide the Medicare information below.

Name of Beneficiary:_____

Policy ID #:_____ Part B Effective Date:_____

IF you selected "No" to (5) above, please provide other insurance information below.

Plan Name:_____

Policy ID #:_____ Group #:_____

Phone # for Providers_____

IF you are not the policyholder for an insurance plan above, please provide their information below.

Policyholder Name:_____ Relationship:_____

Policyholder DOB:_____ Employer:_____

Please provide any secondary insurance information you would like to use below.

Plan Name:_____

Policy ID #:_____ Group #:_____

Phone # for Providers_____

Policyholder Name:_____ Relationship:_____

Policyholder DOB:_____ Employer:_____

I have reviewed the above information, and I agree that it is accurate and current.

_____

_____

Patient Signature Date