FYZICAL®
Therapy & Balance Centers

EMERGENCY CONTACT

Name:_____ Date____/____/____

Physical Address:_____
(No PO Boxes)
City:_____ State:_____ Zip:_____

Phone:_____ Cell: _____

Email:_____

In Case of an Emergency, Please Contact:

1) Name:_____ Relationship _____

Work Phone:_____ Home Phone:_____ Cell Phone:_____

2) Name:_____ Relationship _____

Work Phone:_____ Home Phone:_____ Cell Phone:_____

You are responsible for informing persons at New Day Wellness, LLC dba Fyzical Therapy & Balance Centers Gainesville/Chiefland if you have a medical condition that may require immediate first aid. Any medical information provided is confidential. It is your decision and responsibility to inform others if you believe it necessary for your health and safety while working with this office.

Please list any pre-existing medical conditions and allergies below as well as any other vital information about the undersigned's health.

_____

_____

_____

_____

I have voluntarily provided the above contact information and authorize New Day Wellness, LLC dba Fyzical Therapy & Balance Centers Gainesville/Chiefland and its representatives to contact any of the above on my behalf in the event of an emergency.

SIGNATURE _____ DATE _____