FYZICAL Therapy & Balance Centers

Today's Date: _____/_____/_____

PATIENT INFORMATION

LAST NAME: _____ DATE OF BIRTH: _____/_____/_____

FIRST NAME: _____ SEX (CIRCLE ONE): Male or Female

PRIMARY PHONE NUMBER: (_____) - _____ - _____ SECONDARY PHONE NUMBER: (_____) - _____ - _____

EMAIL: _____

ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PREFERRED LANGUAGE: _____

RACE (CIRCLE ONE): BLACK OR AFRICAN AMERICAN HISPANIC WHITE OR CAUCASIAN, NOT HISPANIC

ASIAN, NOT HISPANIC AMERICAN INDIAN OR ALASKA NATIVE OTHER PATIENT REFUSED/NOT REPORTED

ETHNICITY (CIRCLE ONE): HISPANIC NON-HISPANIC PATIENT REFUSED

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED

INSURANCE INFORMATION *(Please complete the bottom and give your insurance card to the receptionist if you haven't done so at check in)*

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y _____ N _____IF YES, PLEASE NOTIFY THE RECEPTIONIST. If no, please complete the following:

Primary Insurance: _____ I.D. Number _____

Group Number: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____/_____/_____

Relationship to patient: _____

Secondary Insurance: _____ I.D. Number _____

Group Number: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____/_____/_____

Relationship to patient: _____

UPDATED: _____ _____ _____ _____ _____ _____