FYZICAL
Therapy & Balance Centers

516-568-4444

PATIENT INFORMATION

Last Name: _____First_____ Middle Initial_____

State:_____ City_____ House#/Street:_____ Zip:_____

Home Phone ( ) _____ Work Phone ( ) _____

Social Security # _____ Sex ☐ Male ☐ Female Date of Birth: _____

Employer: _____ Occupation: _____

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Marital Status: ☐ Married ☐ Single Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

INSURANCE INFORMATION- If your condition is the result of a work or auto-related accident immediately inform the receptionist so we may give you the appropriate paperwork.

Primary Insurance: _____

Name of Insured_____ Employer of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other: _____

Insurance ID #_____ Insured Date of Birth:_____

Secondary Insurance _____

Name of Insured_____ Employer of Insured:_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other:_____

Insurance ID #_____ Insured Date of Birth:_____

PLEASE READ BEFORE SIGNING:
I authorize FYZICAL Therapy & Balance Centers to release any information to my insurance company that is necessary to expedite the payments of my claims. I understand that I am responsible for all charges not covered by my insurance company including co-payments, co-insurances, and deductibles. ***IF FYZICAL Therapy & Balance Centers IS FORCED TO SEND MY ACCOUNT TO A COLLECTIONS AGENCY, I UNDERSTAND I WILL BE CHARGED THE FULL BALANCE OF MY ACCOUNT AS WELL AS ANY INCURRED COLLECTION FEES.***

Patient Signature (or parent/ legal guardian) _____ Date: _____

Questions??
Contact us by:
Phone: 516-568-4444
FAX: 516-679-2684
E-Mail:
lobergh@Advance-pt.com

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PATIENT HISTORY

Full Name: _____ **Date:** _____ **Age:** _____ **Sex** ☐ **Male** ☐ **Female**

Please give the condition you want treated?_____ **Height**_____ **Weight**_____**(Mandatory for Medicare pts)**

How long have you had this complaint? _____ **Referring Physician:**_____

Is your injury the result of a work or auto related accident? ☐ **Yes** ☐ **No If yes:** ☐ **Work** ☐ **Auto**

Have you previously had this condition? If yes ,explain:_____

_____

List all previous physical therapy and other treatments you have received for your condition:_____

Have you had any physical therapy treatment in the past year? (Please list dates/#visits)_____

List all of your medical conditions so we can safely evaluate and treat you (ex: high blood pressure, allergies, cardiac conditions, past surgeries, pregnancy, etc.):

_____

_____

Please list all medications (prescription and over the counter or supplements) you are currently taking_____

_____

How did you come to our practice? ☐ **I am a former patient** ☐ **My insurance Company Website**

☐ **I saw your ad in the yellow pages** ☐ **I am a World Gym member**

☐ **Doctor** _____ **Drs. Office staff member(list name)**_____

☐ **Family Member or Friend** **(please name so we may thank them)**_____**OTHER**_____

☐ ***I visited your web site*** ☐ ***Direct Web Search*** ☐ ***Google Search*** ☐ ***Bing/Yahoo Search***

Privacy Policy Acknowledgement: FYZICAL will share your information **only** as it relates to your treatment. A copy of our privacy policies is always available at our front desk and waiting area. **Please sign below** acknowledging our policy and its availability. **Please Sign Here:**_____

PLEASE CALL US WITH ANY QUESTIONS: 516-568-4444