# Fyzical Therapy & Balance Centers

6801 Indiana Ave Lubbock, TX 79413 806.785.7900
Southwest Clinic 5244 114th St Lubbock, TX 79424 806.705.8819

**Patient Information (please complete in blue/black ink)** DATE:_____

**How did you find out about us?** ☐ Physician's Office ☐ Family/Friend ☐ Prior Patient ☐ Internet ☐ Our Website ☐ Facebook/Social Media ☐ Home Health Agency ☐ Phonebook ☐ Other _____

_____
Last Name (use full name on insurance card) First Name MI

_____
Street Address City State Zip Code

_____
For Insurance Purposes Gender (M/F) Employer's or School's Name and Address

_____
Home Phone Cell Phone Work Phone Ext. E-Mail Address

_____
Date of Birth Age Social Security Number Marital Status

_____ Appointment Reminders: **Text or Email**
Spouse's Name Spouse's Phone Number (Please circle one)

**RESPONSIBLE PARTY:** (if different from patient information)

_____
Last Name First Name MI

_____
Street Address City State Zip Code

_____
Gender (M/F) Employer's or School's Name and Address

_____
Home Phone Cell Phone Work Phone Ext. Drivers License #

_____
Date of Birth Age Social Security Number Marital Status Spouse's Name

**Was this illness/injury related to an accident?** If yes, please explain (date, location, and how it happened)

_____

_____

**Have you been seen for ANY Home Health Services within the last six months?** _____ Yes _____No

**Have you participated in ANY Physical/Speech Therapy since January 1st of this year?**___ Yes ___ No
If yes to either question, please explain by whom, for what and dates seen _____

_____

**Is this visit work related?** Circle: (Yes) or (No) If yes, date and time it occurred:_____

On work related injures, if your employer fails to pay this bill, you, the patient are responsible for the charges.

**EMERGENCY CONTACT INFORMATION (other than the person you reside with)**:

Last Name First Name MI

Street Address City State Zip Code

Employer's Name Emergency Contact's Relationship to Patient

Home Phone Cell Phone Work Phone Ext.

**INSURANCE INFORMATION (complete if the patient is not the primary insured on the policy)**
**Carrier One**:

Insurance Company Name & Address

Phone Number Group Name or # Member's Identification Number

Name of Insured Insured's Date of Birth

Insured's Address City State Zip Code

Insured's Social Security Number Insured's Employer Patient's relationship to Insured

**Carrier Two**:

Insurance Company Name & Address

Phone Number Group Name or # Member's Identification Number

Name of Insured Insured's Date of Birth

Insured's Address City State Zip Code

Insured's Social Security Number Insured's Employer Patient's relationship to Insured

**Patient or Responsible Party's Signature**