FYZICAL Therapy & Balance Centers

Registration Form

(Please Print)

DATE:_____

Patient Information

FIRST NAME MIDDLE INITIAL LAST NAME	PATIENT'S BIRTHDATE	PATIENT'S SS#	GENDER ☐M ☐F
MAILING ADDRESS	CITY STATE ZIP CODE		
PERMANENT ADDRESS ☐ Check if the same	CITY STATE ZIP CODE		
PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS (Never given out)	
IN CASE OF EMERGENCY CONTACT - NAME, RELATIONSHIP, PHONE #			

HOW DID YOU HEAR ABOUT US? ☐Doctor ☐Friend ☐Internet ☐Phone Bk ☐Other:_____

Case Information

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN	STATUS ☐MARRIED ☐SINGLE ☐FULL TIME STUDENT ☐PART TIME STUDENT ☐EMPLOYED
CONDITION RELATED TO ☐EMPLOYMENT ☐AUTO ACCIDENT ☐OTHER	PROBLEM / COMPLAINT ☐RIGHT ☐LEFT	
HOW DID THE CONDITION OCCUR?	**DATE OF ONSET**	

Primary Insurance Information

PRIMARY INSURANCE	INSURED'S ID NUMBER	POLICY GROUP #	
INSURED'S FIRST NAME MIDDLE LAST ☐Check if the patient is the insured		INSURED'S ADDRESS	
CITY, STATE, ZIP CODE	INSURED'S PHONE #	INSURED'S BIRTHDATE	GENDER ☐M ☐F
INSURED'S EMPLOYER & PHONE NUMBER	RELATION TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER _____		

Secondary Insurance Information ONLY IF SECONDARY TO MEDICARE

SECONDARY INSURANCE	INSURED'S ID NUMBER	POLICY GROUP #	
INSURED'S FIRST NAME MIDDLE LAST ☐Check if the patient is the insured		INSURED'S ADDRESS	
CITY, STATE, ZIP CODE	INSURED'S PHONE #	INSURED'S BIRTHDATE	GENDER ☐M ☐F
INSURED'S EMPLOYER & PHONE NUMBER	RELATION TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER _____		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Fyzical Therapy & Balance and my insurance company to release any information required to process my claims.

_____ _____

Patient's / Guardian's Signature Sign after printing Date