



**FYZICAL<sup>®</sup>**  
Therapy & Balance Centers

To be completed for patients 19 years and under

TELL US ABOUT YOUR CHILD		
Today's Date: _____		
Child's Name: _____		
Last	First	MI
Child's Birthdate: ____/____/____ Child's Age _____		
Nickname: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
School: _____ Grade: _____		
Hobbies: _____		
Child's Home # (____) _____ SS# _____		
Child's Home Address: _____		
_____		
City	State	Zip

GENERAL INFORMATION	
Who is accompanying the child today?	
Name: _____	
Relation: _____	
Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Whom may we thank for referring you?	
_____	
Other siblings: _____	
_____	

PARENT'S INFORMATION	
Person responsible for this account: _____ Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
<input type="checkbox"/> Father <input type="checkbox"/> Step-Father <input type="checkbox"/> Guardian	<input type="checkbox"/> Mother <input type="checkbox"/> Step-Mother <input type="checkbox"/> Guardian
Name: _____ Birthdate ____/____/____	Name: _____ Birthdate ____/____/____
Address (if different from child's) _____ Home #: (____) _____	Address (if different from child's) _____ Home #: (____) _____
_____	_____
City State Zip	City State Zip
Email: _____	Email: _____

RELEASE	
I certify that my child is covered by _____ Insurance Company and I assign all insurance benefits other-wise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize Fyzical to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.	
_____	_____
Signature of Parent or Guardian	Date