FYZICAL®
Therapy & Balance Centers

REGISTRATION FORM

Today's Date:			**Primary Care Physician:**		
PATIENT INFORMATION					
Patient Name: [Last}	**[First]**	**[Middle Initial]**		**Marital Status:**	
Is this your legal name? □ Yes □ No	**If not, What is your legal name?**	**Former Name:**	**Birth date:**	**Age:**	**Sex:** □ Male □ Female
Address: [Address/P.O Box, City, State, Zip Code]					
Social Security #:	**Home phone #:**	**Cell phone #:**			
Occupation:	**Employer:**	**Employer phone #:**			
EMAIL:					
Chose clinic because/referred to clinic by (please choose one option):	□ **Physician** _____ □ **Other:** _____				
Other family members seen here: (Other patients)					
INSURANCE INFORMATION (Please give your insurance card to the receptionist)					
Person Responsible for bill: (Responsible party)	**Birth date:**	**Address:** (if different)	**Home phone #:**		
Is this person a patient here?	□ Yes □ No	**Is this patient covered by insurance?**	□ Yes □ No		
Occupation:	**Employer:**	**Employer address:**	**Employer phone #:**		
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group Number:	Policy Number:	Co-payment:
Patient's relationship to subscriber:					
Name of secondary insurance: (if applicable)	Subscriber's Name:	Subscriber's S.S. #:	Group Number:	Policy Number:	
Patient's relationship to subscriber:					
EMERGENCY CONTACT:	**Relationship to patient:**	**Home phone #:**	**Work phone #**		

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

_____ _____

Patient/Guardian Signature **Date**

To e-mail by pressing "E-Mail" button, you will need desktop application such as Outlook or Mail. You can also save the PDF and send as an attachment to mbarbour@fyzicalnebraska.com or kfaust@fyzicalnebraska.com.

PRINT E-MAIL