



REGISTRATION FORM

Today's Date:		Primary Care Physician:												
PATIENT INFORMATION														
Patient Name: [Last]		[First]	[Middle Initial]	Marital Status:										
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, What is your legal name?	Former Name:	Birth date:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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): <input type="checkbox"/> Physician _____ <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> 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								