Updated 1-29-24

Balance Mobility & Aquatic Therapy Center

Date:

PATIENT INFORMATION

Date of Birth:	Last Name:	First Name:	
Preferred Name:	Middle Name:	SSN:	Maiden Name:
Gender (Circle One): Male / Female / Other / Prefer Not to Say		**Marital Status (Circle One):** Married / Single / Divorced / Widowed	
Mailing Address:		City:	
State:		Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	
Email:		Would you like appointment reminders? (Circle One): Email Text	
Employer:		Preferred Spoken Language:	

EMERGENCY CONTACT

Name & Relationship:	Phone:

How did you first hear about us? Circle one:

Family or Friend TV Radio Social Media Internet Search Other: _____

REASON FOR VISIT

Have you had any Speech, Occupational, or Physical Therapy this calendar year? Y / N

Any Chiropractic visits this year? Y / N At which facility? _____

What area are we treating today? (ex. back, knee, elbow, etc.):	Date of Injury/Day Symptoms Began?

Accident Related: Y / N Accident Type (circle one): Home Work Auto State of Accident: _____

Referring Doctor: Date of Surgery, If applicable?

Primary Doctor:

INSURANCE INFORMATION ***If patient is <u>NOT</u> the policyholder, please complete the information below***

Primary Insurance:

Subscriber Name: Birth Date:

Subscriber Address (If different from patient's):

Relationship to Patient:

Secondary Insurance:

Subscriber Name: Birth Date:

Subscriber Address (If different from patient's):

Relationship to Patient: