Spinal Balance
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TODAY'S DATE:	PCP:

PATIENT INFORMATION

LAST NAME:	FIRST:	MI:	MARITAL STATUS:
BIRTH DATE:	SEX: ○ MALE ○ FEMALE	EMAIL:	
ADDRESS (STREET, CITY, STATE, ZIP CODE):			
SOCIAL SECURITY NO.:	CELL PHONE:		WORK PHONE:
OCCUPATION:	EMPLOYER:		HOME PHONE:
LIABILITY (AUTO ACCIDENT): ○ YES ○ NO	WORKMAN'S COMPENSATION INJURED ON THE JOB? ○ YES ○ NO		
REFFERED BY :			(PLEASE GIVE REFFERAL TO RECEPTIONIST)

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

PRIMARY INSURANCE:			
SUBSCRIBER'S NAME:	BIRTH DATE:	GROUP NO:	POLICY NO.:
PATIENT'S RELATIONSHIP TO SUBSCRIBER:			
SECONDARY INSURANCE	SUBSCRIBER'S NAME:	GROUP NO.:	POLICY NO.:
PATIENT'S RELATIONSHIP TO SUBSCRIBER:			

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE:	RELATIONSHIP TO PATIENT:	PHONE NO.:

Patient Authorization and Insurance Authorization Assignment

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees, regardless of the insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I hereby authorize Vincent Romviel to furnish information to insurance companies concerning my illness and treatments and I hereby assign the physical therapist all payments for medical services rendered to me or my dependents. I understand that I am responsible for any balance not covered.

PATIENT/GUARDIAN SIGNATURE **DATE**