LIFE FITNESS THERAPY

PATIENT INFORMATION

NAME(first, last): DATE OF BIRTH: AGE:

STREET : CITY: STATE: ZIP:

SSN: SEX: ☐M ☐F EMAIL:

HOME PHONE: CELL: OTHER :

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

WHO REFERRED YOU TO US?

DATE OF INJURY: **CAUSE OF INJURY:** **REFERRING MD:**

EMPLOYMENT STATUS: ☐FULLTIME ☐PART TIME ☐NOT EMPLOYED ☐RETIRED ☐DISABLED

EMPLOYER NAME: PHONE:

STREET ADDRESS:

CITY: STATE: ZIP:

PRIMARY INSURANCE

NAME OF INSURANCE:

MAILING ADDRESS:

CITY:

STATE: ZIP:

PHONE:

POLICY ID #:

SECONDARY INSURANCE

NAME OF INSURANCE:

MAILING ADDRESS:

CITY:

STATE: ZIP:

PHONE:

POLICY ID #:

INSURED INFORMATION(RESPONSIBLE PARTY)

NAME: NAME:

SSN: SSN:

DATE OF BIRTH: DATE OF BIRTH:

STREET ADDRESS: STREET ADDRESS:

CITY: STATE: ZIP: CITY: STATE: ZIP:

EMPLOYER:

ADDRESS: REALTIONSHIP TO PATIENT:

ATTORNEY INFORMATION- IF APPLICABLE

NAME : PHONE: FAX:

STREET ADDRESS:

CITY: STATE: ZIP:

PRIMARY CARE PHYSICIAN/ADDITIONAL PHYSICIANS

PHYSICIAN: PHONE:

PHYSICIAN: PHONE:

EMERGENCY CONTACT: **PHONE:**