Patient Information

Name: ____Today's Date: ______/______/______

( ) Male ( ) Female Date of Birth: ______/______/______ S.S #: ____________________________________

Occupation: ____ Work Phone: (____)____-_____________
Employment status: ( ) Employed ( ) Not Employed ( ) Retired

Home Address: ____
Street Address City State Zip Code

Email Address: ____

Home Phone: (_____)_____-_________________ Cell Phone: (____)____-__________________
Do you give Permission to leave a message on your answering machine? Yes / No

Emergency Contact: ____ Phone: (____)____-__________
Name Relation to patient

Physician Information

Referring Physician:____ Phone: (_______)_______-______________

Primary Care Physician: ____ Phone (_______)_______-_______________

Consent to Treatment/Receipt of Privacy Practices

I, the undersigned, give Back To Balance Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym area is a common area accessed by other patients, and as a result there may be incidental contact with personal health information. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the notice. Back to Balance Physical Therapy reserves the right to modify the privacy outlined in this notice.

Signature: ____ **Date:** _______/_______/_______
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to patient: (If patient is under the age of 18) ( ) Mother ( ) Father ( )Legal Guardian