FYZICAL™
Therapy & Balance Centers

1240 Iroquois Ave, Suite 400
Naperville, IL 60563
630-369-1015
www.FYZICAL.com/naperville

Please print clearly so we may transfer your information to our medical database for proper claim submission.
The privacy and security of your personal health information is very important to us.
Thank you for trusting us with your health care.

PATIENT INFORMATION

First Name: _____ **Middle Initial:**_____

Last Name: _____

If not using first name, I preferred to be called: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Date of Birth: _____ / _____ / _____

Sex: (Please circle) Male Female **Marital Status:** (Please circle) Minor Single Married Divorced Widowed

In case of emergency, who should be notified? Name: _____

Relationship: _____ **Phone:** ( ) _____ - _____

Work Related Injury?: _____ **Auto Related Injury?:** _____ **Date of Injury:** _____ /_____ /_____

Primary Care Physician/Family Doctor(s): _____

Are you currently under the care of a Home Health Agency? _____ **No** _____**Yes, name of company:** _____

How did you hear about FYZICAL - Naperville?: _____

PREVIOUS ADDRESS IF LESS THAN TWO YEARS AT PRESENT ADDRESS:

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

INSURANCE INFORMATION - Who is the policyholder for this account? *Please have your insurance card available for copying.*

Insurance Policy #: _____ **Group #:** _____

Medicare # (if applicable): _____ **Part B Effective Date:** _____ / _____ / _____

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____

Relationship to Patient: _____

If Patient is a Minor:

Responsible Party for Bill: _____ **Relationship:** _____ **Date of Birth:** ____ /____ /_____

Responsible Party Address (if other than above):_____