



**BALANCE + FLOW PHYSIO**  
PHYSICAL THERAPY · CLINICAL PILATES · YOGA

## Patient Registration Form

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ Apt#/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Has had Surgery:  Yes  No (If yes) Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Referring Doctor or Dentist: \_\_\_\_\_

How did you find us?:  Doctor  Friend  Online  Patient  Trainer

Primary Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Auto/Work Comp. Insurance Company Name: \_\_\_\_\_

Claim#: \_\_\_\_\_

Adjuster/Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Injury/Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_