



Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Marital Status: Single Married Divorced Widowed Gender: M F
 Current Address: _____ City: _____ State: _____ Zip: _____
 Permanent Address: _____ City _____ State: _____ Zip: _____
 Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____
 Email: _____ Hobbies: _____
 Social Security #: _____ Occupation: _____ Student: Full-time Part-time N/A
 Referring Physician: _____ AND/OR Referral Source: _____
 Are you covered by health insurance? YES NO
 Policyholder Name: _____ Policyholder Date of Birth: _____
 Policyholder Employer: _____ Policyholder Social Security #: _____
 Have you ever had foot orthotics? YES NO Height: _____ Weight: _____ Shoe size: _____

*****Please allow our staff to make a copy of your insurance card *****

Emergency Information: Name/Relation: _____ Phone: _____

Authorization to release information

I hereby authorize The Functional Performance Center to release any information in the course of my examination or treatment to my doctor and insurance company only.

I also authorize the following people to request/receive any protected health information regarding my treatment, payment, and/or administrative operations related to treatment/payment. I understand that the identity of the authorized individuals must be verified before release of information. (i.e. assistants, secretary/receptionist, spouse, coach, attorney, parents (if patient is over 18), etc.) If no one, please put "N/A".

Name/Relation: _____ Name/Relation: _____



Patient or Legal guardian Signature

Date

Assignment of Benefits

I hereby authorize payment of medical benefits directly to the Functional Performance Center, if any, otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization.



Patient or Legal Guardian Signature

Date