Fishkin Center for Back and Body Wellness, LLC

Patient Information Sheet

Patient Name ______________________________

Street Address ______________________________

City ______________ State ______________ Zip Code ______________

Home Phone ______________ Work Phone ______________

Cell Phone ______________ Email ______________

Date of Birth ______________ Age ______________

Gender Identity _____ Height _____ Weight ______

☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name of Spouse/Partner ______________________________

Your Occupation ______________________________

Who Referred You to our Practice? ______________________________

Please Indicate whether your complaint is the result of: ☐ Auto Accident ☐ Work Related Injury ☐ Other

Medical Information:

Chief Complaint/Reason for Visit ______________________________

Date of Last General Physical Exam ____________ Name of Doctor______________ Phone _________

Allergies ______________________________

List of Medications ______________________________

Do you have ☐ High Blood Pressure ☐ Diabetes ☐ Cardiac Problems?

Filing Insurance Claims:

Payment for services rendered are due at the time of service. As a courtesy, if needed, we will provide you with information to submit your claim to your insurance carrier for you to recoup payment.

Assignment of Benefits, Release of Information and Financial Responsibility:

I understand that I am financially responsible for all charges of services rendered to me. Accounts over 60 days are subject to a 1.5% finance charge per month, rebilling charges, and collection fees.

Signature ______________________________**Date** ______________

(Parent must sign if patient is a minor)