MICHIGAN ENT & ALLERGY SPECIALISTS FYZICAL Therapy & Balance Centers

Today's Date: _____/_____/_____

PATIENT INFORMATION

LAST NAME: _____ DATE OF BIRTH: _____/_____/_____ SSN: _____

FIRST NAME: _____ SEX (CIRCLE ONE): Male or Female

PRIMARY PHONE NUMBER: (_____) - _____ - _____ SECONDARY PHONE NUMBER: (_____) - _____ - _____

EMAIL: _____

ADDRESS: _____CITY/ZIP: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PREFERRED LANGUAGE: _____

RACE (CIRCLE ONE): BLACK OR AFRICAN AMERICAN HISPANIC WHITE OR CAUCASIAN, NOT HISPANIC ASIAN, NOT HISPANIC AMERICAN INDIAN OR ALASKA NATIVE OTHER PATIENT REFUSED/NOT REPORTED

ETHNICITY (CIRCLE ONE): HISPANIC NON-HISPANIC PATIENT REFUSED

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED

INSURANCE INFORMATION *(IN ADDITION to showing your insurance cards to the receptionist, YOU MUST fill out the information below)*

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y _____ N _____

***IF YES, PLEASE PROVIDE* INFORMATION FOR CLAIMS SUBMISSION.**

Claim number: Date of Injury /Accident: Claims Adjusters Name:

Claims Adjusters Phone Number:

If no, please complete the following:

Primary Insurance: _____ I.D. Number _____

Group Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____/_____/_____

Relationship to patient: _____

Address of policy holder (if different from Patient) _____

Secondary Insurance: _____ I.D. Number _____

Group Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____/_____/_____

Relationship to patient: _____

Address of policy holder (if different from the Patient) _____

UPDATED: _____ _____ _____ _____ _____ _____

Scanned in by: _____