

Patient Information Sheet

(Use legal name and indicate any nickname in quotation marks "" after first name) *(Please Print)*

Name: _____
(Last) (First) (Initial)

Previous Name: _____
(Last) (First) (Initial)

Address: _____
(Street Address) (City) (State) (Zip)

SS#: _____ Home Phone: (_____) _____ Marital Status: S M W D Sep

DOB: _____ Cell Phone:(_____) _____ Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____
(Street Address) (City) (State) (Zip)

Primary Care/Family Physician: _____

Referred By: Name & Phone Number: _____

SPOUSE and/or RESPONSIBLE PARTY INFORMATION:

(Give spouse's information even if you are not covered under their insurance)

Name: _____
(Last) (First) (Initial)

Address: _____
(Street Address) (City) (State) (Zip)

Home Phone: (_____) _____ Relationship to You: _____

SS#: _____ DOB: _____ Occupation: _____

Employer: _____ Work Phone: (_____) _____

Employer Address: _____
(Street Address) (City) (State) (Zip)

PRIMARY INSURANCE:

Policyholder: (please circle one) Self Spouse Parent

Insurance Company Name: _____

Insurance ID# (SSN): _____ Group #: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to Fitness Matters, Inc. I authorize payment of medical benefits to Fitness Matters, Inc.

SIGNATURE: _____ Date: _____

