PATIENT INFORMATION DATE_____

_____ _____

Last Name First MI Social Security Number

_____

Address City State Zip

_____ _____ _____

Home Phone Cell Phone Email

M__ F__ Age___ Date of Birth_____ Single__ Married__ Divorced__ Widowed__

In case of emergency, who should we notify? _____

EMPLOYMENT INFORMATION

Employer_____ Occupation_____
Employer Address_____ Phone_____

PRIMARY INSURANCE INFORMATION

Insured's Name_____ DOB_____
Insured SSN# _____ Group/ID#_____
Insurance Company_____ Phone #_____

SECONDARY INSURANCE INFORMATION

Insured's Name_____ DOB_____
Insured SSN# _____ Group/ID# _____
Insurance Company _____ Phone# _____

ASSIGNMENT OF BENEFITS

PATIENT'S OR INSURED'S SIGNATURE: I authorize payment of medical benefits to the undersigned supplier for the services assigned. I authorize the release of any medical or other information necessary to process insurance claims.

Signature of Patient/Insured_____ Date_____

GENERAL MEDICAL INFORMATION

Physician Name_____ Surgery Date_____

Current Medications _____
_____

Please check any conditions that apply:

____High Blood Pressure	___Sleeping Problems	___Arthritis
___Gout	___Dizziness/Fainting	___Emotional
___Varicose Veins	___Diabetes	___Allergies
___Epilepsy/Seizures	___Chest Pain/Heart Attack	___Stroke
___High Cholesterol	___Kidney Disease	___Cancer
___Pneumonia	___Ulcers	___Pregnant

___Other (Please specify below)
_____

Do you have specific goals for your therapy program?
_____
_____

CONSENT FOR TREATMENT: I, the undersigned, do agree and give my consent for WAVEFIT to render care and treatment as considered necessary and proper in evaluating and treating my physical condition.

CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize WAVEFIT to treat the minor patient while I am not present.

The above information has been read and/or explained to me.

_____ _____

Patient/Parent/Guardian Date