



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: _____ Current Student: YES / NO
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 orthotics? YES / NO Height: _____ Weight: _____ Shoe size: _____

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

Emergency Information

Contact Name _____ Phone _____
Contact Address _____
Relation: _____

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.

Patient or Legal guardian 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 Date