Please Print Legibly and make sure you complete all the information on this form.
Once completed please return to front desk along with your Insurance card and Photo ID.

Patient Information

<table>
<tr><td colspan="4">Patient Name First Middle Last</td></tr>
<tr><td colspan="4">Address</td></tr>
<tr><td colspan="4">City, State Zip Code</td></tr>
<tr><td>Home Phone</td><td>Cell Phone</td><td>Work Phone</td><td>Best Number to reach you at?
❒Home ❒Cell ❒Work</td></tr>
<tr><td>Date of Birth</td><td>Social Security #</td><td colspan="2">Email address</td></tr>
<tr><td colspan="4">Martial Status? ❒Minor ❒Single ❒Married ❒Divorced ❒Separated ❒Widowed</td></tr>
<tr><td colspan="4">Who Referred you? ❒ Doctor ❒Hospital ❒Physical Therapist ❒Friend ❒Family ❒Other</td></tr>
<tr><td colspan="2">Referring Physician</td><td colspan="2">Referring Physician Phone Number</td></tr>
<tr><td colspan="2">Primary Care Doctor</td><td colspan="2">Primary Care Doctor Phone Number</td></tr>
<tr><td colspan="4">Language ❒English ❒Spanish ❒Other ________________________</td></tr>
</table>

Employment Information

Your Employer:	Employer's Phone Number
Spouse Employer	Spouse Employer's Phone Number

Insurance Information

Do you have insurance? ❒Yes ❒No

Primary Insurance ____
Address/Phone ____
Policy # ______________________________Group # __________________
Name of Insured ___________________Relationship____________ DOB_______

Secondary Insurance ____
Address/Phone ____
Policy # ______________________________Group # __________________
Name of Insured ___________________Relationship____________ DOB_______

I certify that the information provided by me is true, accurate and complete.

____
Signature of Patient / Guarantor Date

7 West Main Street, Suite 1200, Apopka, FL 32703
Office 407-884-0808 Fax 407-814-8889