THE BALANCE CENTER OF LAS VEGAS

321 N Buffalo Drive Suite 110
Las Vegas, NV 89145
702-341-0606

PATIENT INFORMATION

Patient Name (Last/First/Middle)	Sex M F	Date of Birth	Social Security Number
Address Apt. Number	Marital Status □ Single □ Married □ Divorced □ Widowed		
City/ State/ Zip Code	Home Telephone		
E-mail address	Mobile Telephone		
Employer	Work Telephone		
Name of Spouse	Spouse's Work or Mobile Telephone Number		
Emergency Contact (Other than spouse)	Emergency Telephone Number		
Are you currently having any other physical therapy or chiropractic care? □ Yes □ No	Have you had physical therapy this year? □ Yes □ No		

Have you had any in home medical care this year? □ Yes □ No

If so, name of Home Health Agency ____

Whom may we thank for referring you?	Date of onset of symptoms

INSURANCE INFORMATION

Primary Insurance Company	Name of Insured	Relationship □ Self □ Spouse □ Parent
Date of Birth and Social Security Number of Insured (If other than self)	Employer	
Secondary Insurance Company	Name of Insured	Relationship □ Self □ Spouse □ Parent
Date of Birth and Social Security Number of Insured (If other than self)	Employer	

ACCIDENT INFORMATION (Please complete if your injury is the result of an accident)

Type of accident □ Auto □ Work Related □ Other ____________________	Date of Accident
Claim Number	Case Manager/Adjustor Name and Telephone Number
Name and Telephone Number of Attorney	