NEXT LEVEL
PHYSICAL THERAPY AND ATHLETIC PERFORMANCE

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Name:			
Age:	**Birthdate:**	**Driver's Lic.:**	**State:**
Home Address: _____			
City/State		**Zip**	
Billing Address (if different) _____			
City/State		**Zip**	
Email Address:		**Occupation:**	
Hm Phone:		**Cell Phone:**	
Referring Physician:		**Phone:**	
How did you hear about us?"			
In case of emergency call:		**Relationship to you:**	
Hm Phone:	**Cell Phone:**	**Work Phone:**	
Allergies:			

Have you ever had any of the following? Please check:

☐ **Anemia** ☐ **Asthma** ☐ **Cancer** ☐ **Epilepsy** ☐ **Heart Condition** ☐ **Hepatitis** ☐ **Hypertension**

Medications:

I give Next Level Physical Therapy permission to communicate my appointments and other health concerns to the following individual(s):

1. **Name:** _____ **Relationship:** _____
   Phone: _____- _____- _____
2. **Name:** _____ **Relationship:** _____
   Phone: _____- _____- _____

I hereby authorize the release of any information related to all claims submitted on behalf of myself and/or dependents. I hereby assign to Next Level Physical Therapy and Athletic Performance, all benefits provided by my insurance policy for professional services rendered, and agree to pay all charges not covered by my insurance policy. *I understand that to avoid being charged for a missed appointment, I need to call **24** hours in advance to cancel the appointment.*

Patient Name (Printed):		**Witness Name (printed):**	
Signature:		**Witness Name (Signature):**	
Date:		**Date:**	