THE HEALTHY BACK CLINIC
Michael J. Harmon MPT

PATIENT INFORMATION:

NAME: _____
first middle last

PHONE: (home) _____ (cell) _____

ADDRESS: _____ CITY: _____

ZIP CODE: _____ MARRIED: Y N Date of Birth_____ Age_____

EMPLOYER NAME: _____

ADDRESS: _____ PHONE: _____

OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

How did you hear about The Healthy Back Clinic? _____

May we ask for your Email address? We would like to send you updates for exercises and upcoming events

Email Address_____

The Healthy Back Clinic strives to deliver the best care available while being conscious of the charges that may be accrued. So that you don't find yourself being charged full price for all services rendered we need to make positive identification of the insurance that will be responsible for paying your bill. We are also obligated to determine if your injury is related to an automobile accident or if it's work related since we do not have the option of switching your insurances after treatment begins.

MY INJURY THAT I AM SEEKING TREATMENT FOR :

Is related to an automobile accident? Y N

Is work related and will be filed with Worker's Compensation? Y N