Patient & Insurance Information

Welcome! Thank you for choosing ProAction Physical Therapy for your physical therapy needs. We are dedicated to giving you the best care possible. Please complete ALL of the information below as honestly and accurately as possible, so that we may better serve you. If you have any concerns or questions regarding the information requested, please do not hesitate to ask us.

If you have any changes in the future to your insurance coverage, please notify us immediately.

Name: _____ Nickname: _____ Date: _____
FIRST MI LAST

Address: _____
STREET APT CITY/TOWN STATE ZIP CODE

Email Address: _____ Social Security Number: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____ Ext: _____ Preferred phone number: Home ☐ Cell ☐ Work ☐

Reminder call for scheduled PT appointments: Yes ☐ No ☐ Date of Birth: _____ Age: _____ Gender: Male ☐ Female ☐

Currently employed: Yes ☐ No ☐ Full-time Student ☐ Employer/School: _____ Occupation/Grade: _____

Employer/School Address: _____
STREET CITY/TOWN STATE ZIP CODE

Spouse or Emergency Contact: _____ Alt. Emergency Contact: _____
NAME/RELATION PHONE (CIRCLE: HOME, CELL, WORK) NAME/RELATION PHONE (CIRCLE: HOME, CELL, WORK)

Learned of ProAction Physical Therapy through: MD Referral ☐ Location ☐ Seen as a Previous Patient ☐ Website/Google Search ☐
Friend/Relative Referral ☐ (Name _____) Other ☐ _____

Referring Physician: _____ Primary Care Physician: _____
NAME PHONE NAME PHONE

Have you been seen by another Physical Therapist, Chiropractor, or Massage Therapist for your current condition/diagnosis? Yes ☐ No ☐

INSURANCE INFORMATION: *We must have a copy of your insurance card(s) to properly bill your treatment.*

Primary Insurance Company: _____

Type: _____ Effective Date: _____

Policy #: _____ Group #: _____

Insurance Phone (appears on card): _____

Is the patient the policyholder? Yes ☐ No ☐ If No, then:

Policyholder's Name: _____

Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Policyholder's Gender: Male ☐ Female ☐

Policyholder's Date of Birth: _____

Policyholder's Employer: _____

Policyholder's Social Security Number: _____

Secondary Insurance Company: _____

Type: _____ Effective Date: _____

Policy #: _____ Group #: _____

Insurance Phone (appears on card): _____

Is the patient the policyholder? Yes ☐ No ☐ If No, then:

Policyholder's Name: _____

Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Policyholder's Gender: Male ☐ Female ☐

Policyholder's Date of Birth: _____

Policyholder's Employer: _____

Policyholder's Social Security Number: _____

INJURY INFORMATION:

Condition is related to: Work ☐ Auto ☐ Home ☐ Sport ☐ Other ☐ _____ None/Chronic ☐

Date of Onset/Injury (MM/DD/YYYY): ____/____/____ Affected Body Part: _____ Body Side: Right ☐ Left ☐ Both ☐ N/A ☐

CLAIMS MANAGER OR VOCATIONAL REHAB COUNSELOR NAME: (Worker's Comp/L & I or Injury Accident Only)

Name: _____ Phone: _____ Fax: _____
FIRST MI LAST

Address: _____
STREET APT CITY/TOWN STATE ZIP CODE + 4