Patient & Insurance Information

Welcome! Thank you for choosing ProAction Physical Therapy for your care. We're committed to providing you with the highest quality treatment and service. Please complete **all sections** of the information below as accurately as possible so we can best support your needs and verify insurance benefits.

If you have any questions, we're happy to help. Please notify us promptly if any of your information changes.

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

Address: _____
STREET APT CITY/TOWN STATE ZIP CODE

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

Work Phone: _____ Date of Birth (MM/DD/YYYY): _____/_____/_____ Age:_____ Gender: Male ☐ Female ☐ Other ☐

Preferred phone # for reminder call regarding scheduled appointments: _____ May we leave a message at this phone #? Yes ☐ No ☐

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 you current diagnosis/injury? Yes ☐ No ☐

Other Provider: _____ Other Provider: _____
NAME PHONE NAME PHONE

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: (MM/DD/YYYY): ____/____/_____
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: (MM/DD/YYYY): ____/____/_____
Policyholder's Employer: _____
Policyholder's Social Security Number: _____

INJURY INFORMATION:

Condition is related to: Work ☐ Auto ☐ Home ☐ Sport ☐ Other ☐ _____None/Chronic Condition ☐

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 LAST

Address: _____
STREET APT CITY/TOWN STATE ZIP CODE

Email Address: _____ Claim #: _____ Type: L&I (WA) ☐ Auto ☐ _____ Other ☐ _____