



Patient & Insurance Information

Welcome! Thank you for choosing ProAction Physical Therapy for you 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 + 4

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 + 4

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

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 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 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

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