PROACTION
PHYSICAL THERAPY

REGISTRATION FORM

Today's Date: _____/_____/_____ **All information is needed for insurance billing; please complete.**

PATIENT INFORMATION

Last Name _____ First_____ MI _____

Gender _____ Social Security Number _____ D.O.B. _____

Street Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone_____

Marital Status_____ Email _____ Referred by _____

****How did you hear about us? _____

EMPLOYER INFORMATION

Company Name _____ Address _____

City _____ State _____ Zip Code _____

EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____

Relationship to Patient _____ Phone Number _____

INSURANCE INFORMATION

Name of PRIMARY Insurance Carrier	Name of SECONDARY Insurance Carrier
Name of Insured	Name of Insured
Name of Policyholder	Name of Policyholder
Member ID# Group/Plan#	Member ID# Group/Plan#

I authorize ProAction Physical Therapy to submit to my insurance carrier for medical services rendered. For insurance submission "In Network or Out of Network", benefits are rendered to ProAction Physical Therapy. I understand that I am responsible for payment of services rendered regardless of insurance coverage.

PLEASE CHECK: ☐ **I AM IN "NETWORK"** ☐ **I AM "OUT OF NETWORK"**

Signature _____ **Date** _____