Progressive
Physical Therapy & Wellness

REGISTRATION FORM

Revised 7/17/15

(Please Print)

Today's Date:	Primary Care Physician: Referring Physician:

PATIENT INFORMATION

Date of birth:	Age:	Patient's last name:	First:	Middle:

SSN:	Gender: ☐ Male ☐ Female	Marital Status (circle one) Single / Mar / Div / Sep / Wid	Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Permanent Street Address:			
P.O. Box:	Zip:	City:	State:

Home Phone: ( )	Cell Phone: ( ) Cell Service Provider:	Work Phone: ( )

Email:	**Appointment reminder preference (check one):** ☐ Home phone ☐ Cell phone ☐ Text ☐ Email

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:	Relationship to patient:	Phone: ( )

INSURANCE INFORMATION

INSURANCE PORTION MUST BE COMPLETED FOR ACCURACY

Name of Primary Insurance:	Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other__________	Policy Holder (if not self):	Date of Birth:

Name of Secondary or Supplemental Insurance (if applicable):	Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _________	Policy Holder (if not self):	Date of Birth:

Worker's Compensation Insurance Company Name:	Adjuster's Name:	Adjuster's Phone # :	Claim # :	Date of Injury:
Auto Accident Insurance Company to be Billed:	Insurance Contact Name/Lawyer:	Insurance Contact/Lawyer Phone#	Claim # :	Date of Injury:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Progressive Physical Therapy or insurance company to release any information required to process claims.

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Patient/ Guardian signature *Date*