



Patient Information

Name _____

Address _____

City _____ St _____ Zip _____

Date of Birth _____

Social Sec # _____

Home Phone _____ Cell _____

Employer _____

Address _____

City _____ St _____ Zip _____

Work Phone _____

Occupation _____

Patient Status (Check all that apply)

Full time Part time Student Single Married Other

Emergency Contact _____ Phone _____ Relationship _____

Referring Doctor _____ Primary Doctor _____

Insurance

Primary Plan Name _____

ID # _____

Group # _____

Subscriber Name _____

Secondary Plan Name _____

ID# _____

Group # _____

Subscriber Name _____

Please check if this is Worker's Comp

Patient e-mail address _____

How did you initially hear about PRO-PT? Please circle:

Physician friend family coach Facebook website previous patient



Medical Insurance Registration Form (Page 2 of 3)

PERTINENT MEDICAL INFORMATION

Work related injury? YES NO Are you currently working? YES NO

Full Time: _____ Part Time: _____ Modified Work Duty: _____

Motor Vehicle Accident? YES NO Date of Accident: ____/____/____

Sports Injury? YES NO Date of Injury: ____/____/____ Sport: _____

Other: _____

Brief Description of Current Symptoms: _____

Have you received treatment for these symptoms before? YES NO

If YES what type: _____

What type of testing have you received for this injury:

X-Ray _____ MRI _____ CT Scan _____ Bone Scan _____ Results: _____

Have you had physical/occupational therapy within the last calendar year? YES NO

If YES, was it for your current condition? YES NO Location of previous therapy: _____

Approximately how many physical therapy and/or chiropractic treatments have you received this calendar year?

Physical Therapy Treatments: _____ Chiropractic Treatments: _____

INDICATE IF YOU HAVE ANY OF THE FOLLOWING BY CIRCLING THE CORRECT RESPONSE:

Diabetes	YES	NO	Stroke	YES	NO
Chest pain	YES	NO	Seizures	YES	NO
Heart Disease	YES	NO	Metal Implants	YES	NO
Pacemaker	YES	NO	Dizziness	YES	NO
Headaches	YES	NO	Fractures	YES	NO
Kidney Problems	YES	NO	Skin Allergies	YES	NO
Are you pregnant?	YES	NO	Nausea/Vomiting	YES	NO
Cancer	YES	NO	Asthma	YES	NO
Arthritis	YES	NO	Hypoglycemia	YES	NO
AIDS/HIV	YES	NO	Bladder problems	YES	NO
Latex Sensitivity	YES	NO	Tumors	YES	NO
Hepatitis (A,B,C)	YES	NO	Nervous/Anxious	YES	NO
Psychiatric/Psychological Care	YES	NO	Foot or leg pain/numbness	YES	NO
Have you fallen in the past year?	YES	NO	Sprains or Strains	YES	NO



Medical Insurance Registration Form (Page 3 of 3)

If you answered yes to any of the previous, please explain: _____

Recent Surgery? Explain: _____

Are you currently taking medication? YES NO If yes, please list medications: _____

Please list any known allergies: _____

Our financial policy is as stated:

- All co-pays and patient responsibility portions are due at time of services (when applicable)
- Payment is due in full at time of service unless other arrangements have been made. You are responsible for all durable goods at time of acceptance of goods. We accept cash, checks, and some types of credit cards. PRO-PT will set up a payment plan for balances on an individual basis, as deemed necessary.
- If payment is not received from the insurance carrier or other responsible third party in 90 days, we have the right to bill you directly. Please notify us immediately of any changes in your insurance or coverage.
- Twenty four hour notice is required for copies of medical records and there may be a nominal fee.

I know that verification is not a guarantee of payment and that I am responsible for any unpaid balances left after my insurance.

I authorize PRO-PT to provide me with physical therapy services and to furnish further information to my insurance company, worker's compensation carrier, caseworker, attorney, and my physician concerning my injury and treatment. I understand that I am financially responsible for payment of all services rendered.

Signature: _____ Date: ___/___/___