



Name: _____ Date of birth: ____/____/____
(last) (first) (M.I.)

SS number: _____ Marital Status: M D S Other Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Phone: (home) _____ (cell) _____ E-Mail address: _____

Spouse's full name: _____

Emergency contact: _____ Emergency contact number: _____

Referring MD: _____ Referring MD phone #: _____

Employer: _____ Phone (work): _____

Did a family member or friend recommend us to you? Y N If yes, who was the treating PT? _____

If no, how did you choose us for your physical therapy? Radio Print Ad MD Location Website
Yellow pages Insurance Other: _____

Is your injury/condition a result of a motor vehicle accident? Yes No

Is your injury/condition a result of a work related incident? Yes No

Medicare Only

Have you had any physical/speech therapy so far this year? Yes No

If YES, where and when did you have it: _____

Do you have a home health care agency coming to your house? Yes No

If YES, who is the agency and what is the phone number: _____

Do you have secondary insurance? Yes No

Workers' Compensation/No Fault Only

Ins Co: _____ Address: _____ City: _____ State/Zip _____

WCB#: _____ Claim #: _____ Phone #: _____

Date of Injury/accident: _____ Employer: _____ Employer contact: _____

Employer ph #: _____ Attorney: _____ Attorney ph #: _____

I, _____ hereby authorize and instruct my insurance carrier to pay Primary Physical Therapy, PLLC D/B/A PROActive Physical Therapy, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee of 23% of account balance. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

Insured or Authorized Person's Signature

Date