Progressive Therapy Services
"a total body approach"

## PATIENT INFORMATION

**PATIENT NAME: _____DOB:_____ MALE/FEMALE**

**ADDRESS: _____CITY:_____ STATE____ZIPCODE_____**

**HOME: _____ CELL PHONE: _____WORK PHONE: _____**

**** PLEASE CIRCLE WHICH PHONE NUMBER WE CAN LEAVE A VOICEMAIL REGARDING TREATMENT DATES/TIMES****

**EMPLOYER: _____EMAIL ADDRESS: _____**

**EMERGENCY CONTACT: _____PHONE NUMBER: _____ RELATIONSHIP: _____**

**PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN: _____**

**HEALTH INSURANCE NAMES (S): PRIMARY_____SECONDARY:_____**

**SUBSCRIBER NAME: _____ DOB: _____ RELATIONSHIP: _____**

**MEDICARE: YES / NO MEDICARE ID #:_____**
**** MEDICARE REQUIRES THAT THE PATIENT SEE THEIR PHYSICIAN TO BEGIN TREATMENT**

**HOW DID YOU HEAR ABOUT US? FRIEND PHYSICIAN WEB OTHER: _____**

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**IS THIS A WORKERS' COMPENSATION CLAIM: YES / NO CLAIM NUMBER: _____**

**WORKERS' COMPENSATION INSURANCE COMPANY: _____**

**EMPLOYER: _____ EMPLOYER CONTACT PERSON: _____**

**EMPLOYER ADDRESS: _____ CITY: _____ZIP CODE: _____ STATE: _____**

**ADJUSTER: _____**

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**IS THIS A MOTOR VEHICLE ACCIDENT CASE: YES / NO AUTOMOBILE INSURANCE: _____**

**CLAIM NUMBER: _____ ATTORNEY INVOLVED? YES / NO**

**NAME: _____ PHONE NUMBER: ( ) _____**

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I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing on insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Progressive Therapy Services, LLC of any changes in the above information.

_____ _____

**SIGNATURE DATE**

_____ _____

**(MINORS)- PARENT/ GUARDIAN SIGNATURE DATE**