

**PROGRESSIVE THERAPY & SPORTS MEDICINE**

Date: \_\_\_\_\_

Account # \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date of Script: \_\_\_\_\_

Social Security # \_\_\_\_\_

E-mail address: \_\_\_\_\_

(Internal use only)

PATIENT NAME : \_\_\_\_\_  
(Last) (First) (Initial)

ADDRESS: \_\_\_\_\_

(City) (State) (Zip)

PHONE: (HOME)\_( ) - \_\_\_\_\_ (WORK)\_( ) - \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_ M \_\_\_ F MARITAL STATUS: \_\_\_ M \_\_\_ S \_\_\_ D \_\_\_ W

SPOUSE: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT (NOT RESIDING WITH YOU)**

NAME: \_\_\_\_\_ PHONE ( ) - \_\_\_\_\_

**ACCIDENT DETAILS / REASON FOR VISIT (REQUIRED FOR INSURANCE FILING)**

We will need to copy the front and back of your insurance cards for billing purposes, and to verify coverage. If SELF PAY, you will need to make payment arrangements at your initial appointment. Workers Compensation claims require authorization from the employer or insurance carrier.

WHAT TYPE OF ACCIDENT? (CIRCLE ONE): NONE AUTO WORK OTHER

DATE OF INJURY/ACCIDENT: \_\_\_\_\_ BODY PART: \_\_\_\_\_

DETAILS OF ACCIDENT/INJURY: \_\_\_\_\_

SURGERY: \_\_\_ Y \_\_\_ N DATE OF SURGERY \_\_\_\_\_

**RESPONSIBLE PARTY (PRIMARY PERSON ON INSURANCE IF DIFFERENT THAN PATIENT)**

RELATIONSHIP TO PATIENT: \_\_\_\_\_ SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_ OTHER \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

SOC SEC # \_\_\_\_\_ SEX \_\_\_ M \_\_\_ F BIRTHDATE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_