

 **PROGRESS PHYSICAL THERAPY**
PROGRESS REHABILITATION NETWORK, LLC AFFILIATE

Patient Name: _____
 Address: _____ Last _____ City _____ State _____ MI _____ Zip _____
 Sex: M F Social Security# _____ - _____ - _____ Marital Status: M S D W U Date of Birth ____/____/____
 Home Phone () _____ - _____ Work Phone () _____ - _____ Ext. _____ Cell () _____ - _____
 Email Address: _____ (appointment communication, special classes offered)
 Employer: _____ Occupation _____
 Accident Type: **NONE** **W/C** ____/____/____ **Auto** ____/____/____ **Liability** _____
 (Circle one) Date of Injury Date of Accident Attorney's Name & Telephone

Policy Holder
 Relation to patient: Self _____ Spouse _____ Parent _____ Other _____
 Policy Holder: _____ Date of Birth ____/____/____
 Address: _____ Last _____ City _____ State _____ MI _____ Zip _____
 Social Security # _____ - _____ - _____ Home () _____ - _____ Work () _____ - _____ Ext. _____
 Employer: _____ Employers Address: _____
 * * * * *
Secondary Ins
 Policy Holder: _____ SS# _____ - _____ - _____ DOB ____/____/____
 Address: _____ Last _____ City: _____ State: _____ MI _____ Zip: _____
 Employer: _____ Employers Address: _____
Responsible Party / Guarantor
 Address: _____ Last _____ City: _____ State: _____ MI _____ Zip: _____

I Acknowledge That The Above Information Is Correct

Patient/Guardian _____ Date: ____/____/____

Insurance Verification

Referring Physician: _____ Tel (____) ____/____/____ Fax (____) ____/____/____
 Primary Care Referral Needed? **Y** **N** **PCP:** _____ Tel (____) ____/____/____ Fax (____) ____/____/____
Referral# _____ # of Visits Authorized _____ Start Date: ____/____/____ Expiration Date: ____/____/____
Insurance: _____ **Policy #** _____ **Group #** _____
Telephone : (____) ____/____/____ Spoke with _____ Effective Date: ____/____/____
 Co Pay: _____ Percentage: _____ Deductible: _____ Max Visits allowed _____
 Comments: _____
 Billing Address: _____ City: _____ State: _____ Zip: _____
DX: _____
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Secondary Ins: _____ **Policy #** _____ **Group #** _____
 Billing Address: _____ City: _____ State: _____ Zip: _____
 Comments: _____