ProCare Therapy Services
Patient Registration Form

☐ Mr. ☐ Miss
☐ Mrs. ☐ Ms. Last Name _____ First: _____ M.I. _____
Sex: ☐ M ☐ F Social Security # _____ Birth Date _____ Age _____

Patient Information: **Date:**

Address:	City:	State: Zip:
Phone – Home or Cell (Please circle):	Email:	Marital Status: (Circle) S / M / D / Sep / W/
Preferred method of contact:	Appointment Reminders (Circle One): Voice / Text / Email	
Occupation:	Employer:	Employer Phone:
Emergency Contact Name:	Relationship:	Phone:

Reason for Today's Visit

Date of Onset _____ _____ Chronic _____ New Injury _____ Accident _____ Work Related

Description of Problem _____

How did you hear of ProCare Therapy Services? _____

Who can we thank for referring you? _____

Referring Physician:

Name:	Address, City, State:	Phone:

Insurance Information:

Primary Insurance:	Group Number:	Policy (ID) Number:
Subscriber Name:	Subscriber Social Security Number:	Subscriber Birth Date:
Patient Relationship to Subscriber:	Co-Payment:	
Secondary Insurance:	Group Number:	Policy (ID) Number:
Subscriber Name:	Subscriber Social Security Number:	Subscriber Birth Date:
Patient Relationship to Subscriber:	Co-Payment:	

The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize ProCare Therapy Services or insurance company to release any information required to process my claims.

Patient Signature: _____ **Date:** _____