ProActive
REHABILITATION & WELLNESS

2103 Reedale Ave
Augusta, GA 30906
(706) 814-6887

New Patient Registration

Personal Information

Name:		Name you prefer:
Home Address:		
City:	State:	Zip Code:
Mailing Address: ☐Same		
City:	State:	Zip Code:
Diagnosis:		
Date of Injury/Onset of symptoms:	Marital Status: ☐Married ☐Single ☐Separated ☐Divorced	
Date of Birth:	Age:	Sex: ☐ Male ☐ Female
Home Phone:☐Preferred	Best time to call:	
Work Phone: ☐Preferred	Best time to call:	
Cell Phone: ☐Preferred	Best time to call:	
Email Address:		
Emergency Contact/Relationship:		Phone:
How did you hear about us?		

Physician Information

Referring Physician Name:	Phone:
City, State, Zip:	
Primary Care Physician Name:	Phone:
City, State, Zip:	
Other physicians you would like information released to and phone numbers.	

Employment Information

Employer Name:	Occupation:
Address:	City, State, Zip:
Social Security Number (For insurance verification):	Phone:

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Primary Insurance Information

Is this an auto accident? Yes No		Is this a work-related injury? Yes No
If "Yes", list claim # and adjuster contact information:		
Health Insurance Company Name:		Phone:
Policy / ID#:		Group#:
Subscriber's Name:☐Same		Subscriber's Date of Birth:
Relationship to the Subscriber:		
Subcriber's Address:☐Same		Phone:
Address:	City/State:	Zip:

Secondary Insurance Information

Health Insurance Company Name:		Phone:
Policy / ID #:		Group#:
Subscriber's Name:☐Same		Subscriber's Date of Birth:
Relationship to the Subscriber:		
Subcriber's Address:☐Same		Phone:
Address:	City/State:	Zip

Guarantor Information

Employer Name: ☐Same	Occupation:
Address:	City, State, Zip:
Social Security Number (For insurance verification):	Phone:

I certify that the information on this form is complete, true & accurate.

_____ _____

Patient/Guardian Printed Name Patient/Guardian Signature/Date