



**Agility Physical Therapy & Sports Performance, LLC**

6016 Lovers Lane, Suite 3 | Portage, MI 49002 | T. 269.329.0934 | F. 269.329.0965 | www.agilitysportsmedicine.com

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle Initial

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
Street Address (including apartment number or P.O. Box)

City \_\_\_\_\_ State \_\_\_\_\_ Zip + 4 \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Sex: F / M Marital Status (optional): Single / Married / Divorced / Widow

Employer: \_\_\_\_\_  
Name City / State

Emergency Contact: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone Number

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_  
Name Relationship to Patient

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Street City State Zip

Insurance Information: *Please present insurance cards at initial visit*

**Primary Insurance**

Policy holder: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient: Self Spouse Parent Guardian Other: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy / ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Secondary Insurance**

Policy holder: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient: Self Spouse Parent Guardian Other: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy / ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Office Visit Co-pay (If known): \_\_\_\_\_