re + ACTIVE
therapy and wellness

Patient Information

Last Name:_____ First Name: _____ Middle Initial: ___

Referring/Treating Physician or Healthcare Provider: _____

Dx/Reason for Visit: _____ Date of RX (if applicable): _____

Date of Birth:_____ Gender Listed on Insurance: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Other

Home Address:_____Apt #_____

City:_____State:_____ Zip: _____

Home Phone:_____ Cell Phone: _____

E-mail address: _____

Would you like to receive appointment reminders? ☐ Text ☐ E-mail ☐ None

May re+ACTIVE Physical Therapy contact you via email for billing purpos ☐ es ☐es ☐ No

Employer:_____ Occupation: _____

Spouse Name:_____ Spouse Employer:_____

How were you referred to re+ACTIVE: _____

Insurance Information

Name of Primary Insurance: _____

Policy Holder Name:_____Relationship to Patient: _____

Policy Holder Date of Birth: _____ Group # _____ Policy/ID # _____

Billing Address (for statements to be sent): _____

City: _____ State: _____ Zip: _____

Ins Phone: _____

Name of Secondary Insurance: _____

Policy Holder Name:_____Relationship to patient: _____

Policy Holder Date of Birth:_____Group#_____Policy /ID #_____