# ACTIVE PHYSICAL THERAPY & WELLNESS, LLC

2 Lodge Lane
Wilbraham, MA 01095

## PATIENT INFORMATION

Patient Name: _____
First MI Last

Address: _____City:_____ State:_____ Zip Code: _____

Telephone: (Home) (_____) _____-_____ (Work) (_____) _____-_____

(Cell) (_____) _____-_____ E-Mail Address: _____

Soc. Sec. #: _____/_____/_____ Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Child

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Telephone:(_____)_____-_____

Referring Physician Name:_____ Primary Care Physician:_____

## BILLING INFORMATION *(Insured)*

Insured's Name:_____
**(Name of person who carries the insurance)**

Address: _____

City:_____ State:_____ Zip Code:_____

Soc. Sec. #: _____/_____/_____ Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Child

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: (_____)_____-_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

## INSURANCE INFORMATION

***** Please give us your insurance card(s) so we may copy*****

Insurance Name #1: _____
Insurance Name #2: _____
**Is this a Workman's Comp**: ☐ Yes ☐ No Claim #:_____ Date of Injury: _____ State: _____
**Is this a Motor Vehicle Accident**: ☐ Yes ☐ No Claim #:_____ Date of Injury: _____ State:_____

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to Active Physical Therapy & Wellness, LLC. ***Any charges not covered by my insurance will be my responsibility***.

_____ _____
Patient Signature/Authorized Representative Date