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) (_____) _____-_____

Date of Birth: _____/_____/_____ Sex: _____ Preferred Pronouns:_____/_____

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: (_____) _____-_____

Email:_____Would you like to receive occasional email updates from us? ____Yes ____No

Referring Physician Name: _____ Primary Care Physician: _____

BILLING INFORMATION

Insured's Name: _____

(Name of person who carries insurance)

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Sex: _____

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 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**