**P H Y S I O T H E R A P Y**
***A c t i v e R e h a b***

---

******EXTENDED HEALTH******

***PATIENT INFORMATION***

Today's Date ___________________ Date of Birth M__ F__

Name (Last) ______________________________(First) ____________________________

Street Address ________________________________________________________________

City ____________________________ Postal Code __________________

Phone # (home) ________________(cell #)_________________(work #) _____________

Emergency Contact: (name) _______________________(phone #) ____________________

Email : _______________________________________________

***FAMILY PHYSICIAN***

Name ______________________________ Phone # _________________________________

***EMPLOYER INFORMATION***

Company Name ___________________________ Occupation _______________________

***EXTENDED HEALTH CARE INFORMATION***

1ST Insurance company name __________________________________________________

Policy # ___________________________ Id #____________________________________

Policy holder name ______________________ Date of Birth _______________________

2nd Insurance company name __________________________________________________

Policy # ___________________________ Id #____________________________________

Policy holder name ______________________ Date of Birth _______________________

***I am covered under only one insurance policy ____ Signature ___________________***

***I am covered under a secondary insurance policy ____Signature__________________***

For Office Use Only

1st- PHYSIO : Yr Max-________ Visit Max-_______ %-_________ Doc Ref -________ Validity -________

MASSAGE : Yr Max-_________ Visit Max-_______ %-___________ Doc Ref-________ Validity-_________

ORTHOTICS : (Dispensed by Physio?_____) INSERTS: __________ Max per yr-_________ %-_________ Doc Ref-________ Validity-________

SHOES: ___________ Max per yr-______ %-________ Doc Ref-_________ Validity-_________

TENS: Yr Max-________ %-____________ Doc Ref-_______ Estimate-______ Validity-_______

DEDUCTIBLE: Ind____ Fam____ DIR PAY: Y___N___ BEN YR: _______ SUB EXP: _________ MAILING ADDRESS: ____________________ SPOKETO/TIME/DATE: _____________________

2nd-PHYSIO : Yr Max-________ Visit Max-_______ %-_________ Doc Ref -________ Validity -________

MASSAGE : Yr Max-_________ Visit Max-_______ %-___________ Doc Ref-________ Validity-_________

ORTHOTICS : (Dispensed by Physio?_____) INSERTS: __________ Max per yr-_________ %-_________ Doc Ref-________ Validity-________

SHOES: ___________ Max per yr-______ %-________ Doc Ref-_________ Validity-_________

TENS: Yr Max-________ %-____________ Doc Ref-_______ Estimate-______ Validity-_______

DEDUCTIBLE: Ind____ Fam____ DIR PAY: Y___N___ BEN YR: _______ SUB EXP: _________ MAILING ADDRESS: ____________________ SPOKETO/TIME/DATE: _____________________