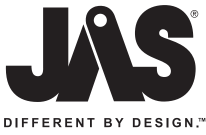

2600 S Raney Effingham, IL 62401
PHONE: **800-879-0117**
FAX: **217-347-3384**
www.jointactivesystems.com
info@jointactivesystems.com

PATIENT INFORMATION FORM

Complete & Fax to:

JAS Sales Representative: ____________________

Patient Information ** JAS devices require a physician's prescription*

☐ Male ☐ Female Height _____ft _____in Weight _________

Patient Name ______________________ D.O.B. ____________

Address ______________________ City ____________ State ______ Zip ________

Phone # Home ____________ Cell ____________ Work ____________

Employer ____________ Social Security Number____________

Guarantor Name ______________________ D.O.B. ____________

Relationship to Patient______________________

Prescribing Physician ____________ Address ____________

City ____________ State ________ Zip ________ NPI # ____________

Phone ____________ Fax ____________

Primary Diagnosis ____________ Secondary Diagnosis ____________

Date of Onset / Injury ____________ Date of Surgery ____________

Therapy Clinic ____________ PT/OT ____________

Address____________ City____________ State/Zip____________

Phone ____________ Fax ____________ Email____________

Insurance Information **Please provide a copy of the Insurance Card*

Claim Type: ☐ Work Comp ☐ Insurance ☐ Medicare ☐ Other ____________

Primary Insurance Name & Address____________

City ____________ State________ Zip________ Policy Holder____________

Policy/Claim # ____________ Group # ____________

Ins Phone # ____________

Claim Rep ____________ Phone # / Extension ____________

Secondary Insurance ____________ Policy #____________

Group # ____________ Phone #____________

Indicate Ship to Address: ☐ **Clinic** ☐ **Patient** ☐ **Rep** ☐ **Other**____________

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