JAS®
THE ROM SPECIALISTS®
2600 S Raney Effingham, IL 62401
PHONE: 800-879-0117
FAX: 217-347-3384
www.jointactivesystems.com

PATIENT INFORMATION FORM

Fax to: 217-347-3384
Email to: orders@jointactivesystems.com

JAS Sales Representative: _____

Patient Information

** JAS devices require a physician's prescription*

☐ Male ☐ Female Height _____ft _____in Weight _____ Language Spoken_____

Patient Name _____ D.O.B. _____

Address _____ City _____ State _____ Zip _____

Phone # Home _____ Cell _____ Work _____

Email Address _____

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 _____

Device Being Ordered _____ Date of Onset / Injury _____ Date of Surgery_____

Therapy Clinic_____ Therapist Name _____

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_____