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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 _____