ACTIVE REHAB, INC

New Patient Intake Form

Patient's Details

Last Name:	**First Name:**	**Date of Birth:**	**Male/Female**
Home Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Email:**	

Referring Physician's Name:	**Phone Number:**
Address:	**NPI Number:**

Physician's Details

Details of Condition:

Patient's Diagnosis:	**Date of Onset/ Injury:**
Referral Date:	

Primary Insurance

Insurance Name:	**ID Number:**
Group Number:	**Claim Number:**
Deductible:	**Max Annual Benefit:**
Copay:	**Coinsurance:**

Policy Holder details if not patient.

Policy Holder, Name and DOB and SS#, if not the client:
Policy Holder's Relation to Patient: Self Spouse Parent Other

Secondary Insurance

Insurance Name:	**ID Number:**
Group Number:	**Claim Number:**
Deductible:	**Max Annual Benefit:**
Copay:	**Coinsurance:**

Insurance Holder (If Different From Patient)

Policy Holder, Name and DOB and SS#, if not the client:
Policy Holder's Relation to Patient: Self Spouse Parent Other

Are you currently receiving or have recently received care from any Home Health Agency providing Nursing ,Physical , Speech or Occupational Therapy Services in the past 30 days?

☐ Yes

☐ No

If yes, then what is / was the discharge date you were seen by your therapist/nurse?

_____

What is the name of your Home Health Agency? _____

Telephone Number of your Home Health Agency?_____

Phone Number: 248-730-0414
Fax Number: 248-694-0916
Email Address: activerehabinc@gmail.com | info@activerehabinc.com