Patient Enrollment Form

activemarin
Physical Therapy and Wellness

Patient Demographics

Name (last, first): _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ SSN # (Medicare Patients): _____

Pediatric Patient Demographics

If you are completing forms on behalf of a minor or legal dependent, please provide your contact information below. Otherwise, please skip to the next session.

Parent/Guardian Name (last, first): _____ DOB: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Medical Provider

Please provide the name and contact information for the doctor that referred you for physical therapy. If you do not have a prescription or referral, please provide the name and contact information for your primary care physician.

Physician Name: _____ City: _____

Phone: _____

Work/Auto Claims

Is your treatment related to a work injury or auto accident? ☐ Yes ☐ No

Referral Information

How did you hear about Active Marin Physical Therapy?

☐ Prescribing Doctor

☐ Someone Else : _____

☐ Myself – Online (Website, Facebook, Yelp, Google, Other): _____

☐ Myself – Offline (Repeat Visit, Storefront, Event, Other): _____

_____ _____

Signature Date