Revive Health Center
Personal Injury Clinic

PATIENT REFERRAL FORM

844.303.5815 239.309.0604
FAX COMPLETED FORM TO: **954.388.0466**
INFO@REVIVEHEALTH.CENTER | REVIVEHEALTHCENTERFL.COM

PATIENT INFORMATION

PATIENT NAME: _____ PHONE NUMBER: _____

DATE OF BIRTH: _____ DATE OF ACCIDENT: _____

PATIENT ADDRESS: _____

REFERRING PHYSICIAN: _____

PHYSICIAN PHONE NUMBER: _____ PHYSICIAN FAX NUMBER: _____

ATTORNEY: _____

ATTORNEY PHONE NUMBER: _____ ATTORNEY FAX NUMBER: _____

DOES THE PATIENT HAVE MRI'S? ☐ NO ☐ YES (If yes, please send the MRI report with the referral.)

PIP INSURANCE CARRIER: _____

INSURANCE PHONE NUMBER: _____ INSURANCE FAX NUMBER: _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

PIP ADJUSTER: _____

ADJUSTER PHONE NUMBER: _____ ADJUSTER FAX NUMBER: _____

BILLING ADDRESS: _____

REASON FOR VISIT:

☐ Interventional Pain Management ☐ Chiropractic Evaluation ☐ Massage Therapy ☐ Other: _____

Complaints: ☐ Neck ☐ Back ☐ Shoulder ☐ Knee ☐ Other: _____

REV 6/2025

PREFERRED LOCATION:

☐ **Orlando**
3847 Oakwater Circle
Unit 4
Orlando, FL 32806

☐ **Tampa**
4019 W Waters Ave
Suite B
Tampa, FL 33614

☐ **Tampa**
4730 N Habana Ave
Suite 104
Tampa, FL 33614

☐ **Fort Myers**
12500 Brantley Commons Court
Unit 1 & 2
Fort Myers, FL 33907