Restore Occupational Therapy
693 Main Street
New Milford, PA 18834

Patient Information:

Name: _____ D.O.B _____ Date: _____

Address: _____

Home phone: _____ Cell phone: _____

Email address: _____ Primary Care MD: _____

Referring MD: _____Date of Injury: _____ Date of Surgery:_____

Nature of injury/surgery: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ Plan Name:_____

Type: (circle) PPO HMO POS Medicare Medicaid Tricare W/C

Policy#: _____ Group#: _____

Effective Date: _____ Guarantor Full Name: _____

Guarantor DOB and address if different from above:

_____

Secondary Insurance: _____ Plan Name:_____

Type: (circle) Medicaid Medicare Supplement Commercial Other_____

Policy#: _____ Group#: _____

Effective Date: _____ Guarantor Full Name: _____

Guarantor DOB & Address: _____

Acknowledgement: The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in the clinic's Notice of Privacy Practices. I authorize my insurance benefits to be paid directly to Restore as indicated on the claim. I understand that I am financially responsible for all fees and balances regardless of insurance coverage.

_____ _____

Patient/Guardian Signature Date