Heritage PT
2891 E Maple Rd., Ste 103
Troy, MI 48083

PATIENT INFORMATION SHEET

REFERRED BY____

PATIENT'S NAME____
(LAST) (FIRST) (MI)

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP CODE)

PHONE # ____________________ DATE OF BIRTH_________________SS#_________________

SEX: M__F__ MARITAL STATUS: S:____ M: ____ D:_____ SEP: _______________

IN EMERGENCY CONTACT PH#

INSURANCE INFORMATION

BC/BS ____
(CONTRACT #) (GROUP#) (SUBSCRIBER NAME/RELATION)

MEDICARE #_________________________ MEDICAID #________________________________

OTHER INSURANCE:____

AUTO INSURANCE: ____

ADDRESS: ____

ADJUSTER NAME: ___________________________PH # ________________________________

DATE OF ACCIDENT____

WORKMAN'S COMP.____

I THE UNDERSIGNED HAVE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO EURO REHAB ALL MEDICAL BENEFITS IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZED EURO REHAB TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENTS.

DATE:__________________PATIENT'S SIGNATURE_____________________________________