Orthotic & Prosthetic Design

Patient Registration

PATIENT INFORMATION

Thank you for choosing our office; in order to serve you properly and process your claim, we need the following information. Please Print.

Mr./Ms./Mrs. ______________________ ________ ______________________
First MI Last

Address ______________________ Home Phone (____)______________

______________________ Work Phone (____)______________

City ______________ State __________ Zip Code ______________

Emergency Contact ______________________ Phone (_____)______________

Guarantor ______________________ Patient Rel to Guarantor: Self Spouse Child Other __________

Guarantor Address ______________________ Phone (____)______________ Power of Attorney: Y N

Soc Sec # ______________________ Marital Status: Single Married Divorced Widowed Other

DOB ______________________ M or F

Referring Physician ______________________ Phone (____)______________

Primary Care Physician ______________________ Phone (____)______________

Are you a diabetic? Y or N If yes, name and address of physician treating your diabetes:

Name ______________________ Phone (_____)______________

Address ______________________

Is your condition result of an injury? Y or N Date of injury ______________

If yes, what type of injury was sustained? ______________________

Was injury work related? Y or N If yes, name of employer at time of accident: ______________

Employer Name ______________________

Address ______________________

City______________ State __________ Zip __________

Contact Person______________________ Phone (____)______________

Claim # ______________________

Was injury result of an automobile accident? Y or N If yes, name of adjuster: ______________

Name ______________________ Phone (____)______________ Claim # ______________

Current Employer______________________

Your email address ______________________ Cell Phone (____)______________

INSURANCE INFORMATION

Primary Insurance ______________________ Phone (____)______________

Policy # ______________________ Group # ______________

Address ______________________

Name of Insured ______________ Relationship ______________ DOB __________

Secondary Insurance ______________________ Phone (____)______________

Policy # ______________________ Group # ______________

Address ______________________

Name of Insured ______________ Relationship ______________ DOB __________

ASSIGNMENT OF BENEFITS/ AUTHORITY FOR RELEASE OF INFORMATION

I hereby authorize and request my insurance company to pay directly to Orthotic and Prosthetic Design, Inc. The amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount paid by the insurance company be insufficient to cover the entire orthotic and prosthetic expense, I understand that I am financially responsible for payment of the difference, and if the nature of the injury or disability be such that it is not covered by the policy, I will be responsible to Orthotic and Prosthetic Design, Inc. for payment of the entire bill. I further authorize and give my permission to release all confidential medical information necessary to any carrier listed on the claim for the purpose of processing this or any related medical claim to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that telephone inquiries to my insurance company are not a guarantee of coverage benefits. We (Orthotic and Prosthetic Design, Inc.) have attempted to estimate you balance due. However, after a review by your insurance company, you may owe an additional amount. This assignment will remain in effect until revoked by me in writing.

____
Signature of Patient / Guarantor

____
Date

____
Relationship to Patient