# 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