Adaptive Prosthetics & Orthotics Patient Information

Please Print

Patient Name _____ ☐ Male ☐ Female
Last First M.I.

Physical Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Birthdate _____/_____/_____ **Social Security #** _____- _____ - _____

Home # (_____) _____ **Cell #** (_____) _____

Employer: _____ **Work #** (_____) _____

Emergency Contact: _____**Relationship**: _____**Phone:** _____

Responsible Party: _____ **Relationship:** _____

Address _____
Street City State Zip

Home # (_____) _____ **Cell** (_____) _____

Referral Source: _____

Primary Care Doctor: _____

Are you Diabetic? ☐ Yes ☐ No

Who treats you for your diabetes? _____

Primary Insurance:	**Secondary Insurance:**
If insured is other than self, please complete the following	***If insured is other than self, please complete the following***
Insured Name:	Insured Name:
Insured Birthdate:	Insured Birthdate:
Insured SS#	Insured SS#

Is your condition a result of an injury or accident?

☐ Yes
☐ No

If yes, date of accident _____

Workers compensation company: _____
Phone # _____
Contact Name: _____
Claim No: _____

In consideration of professional services rendered, I hereby assign benefits due me covering the services under the above public or private insurance policy number sot Adaptive Prosthetics and Orthotics. I authorize any holder of medical information about me to release to the above insurance company and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I agree that should the amount be insufficient to cover the entire expenses for the professional services, I will be responsible for payment of the difference and that the nature of the disability be such that it is not covered by the said policy, I will be responsible for payment for the entire bill forthwith.

I HAVE RECEIVED A COPY OF THE MEDICARE SUPPLIER STANDARDS, APO'S WARRANTY, AND APO'S NOTICE OF PRIVACY ACTS

_____ _____

Signature (Patient or Responsible Party) **Date**