

PROSTHETIC AND ORTHOTIC CARE, INC.

Thank you for choosing our office. In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Patient's Full Name _____ Date: _____
Street Address _____ City _____ State _____ Zip _____
E-Mail Address _____ Sex: M F Age _____ Birthdate _____
Home phone number() _____ Work phone number() _____
Social Security # _____ Marital Status: Single / Married / Widowed / Separated / Divorced
Spouse/Parent Name/Guardian (Circle one) _____ Phone # () _____
Spouse/Parent Name/Guardian Address _____
In case of emergency, who should be notified? _____ Phone # () _____

Primary Care Physician _____ Referring Physician _____
Diagnosis/Type of injury _____ Cause of injury _____

Is injury related to (Circle one) Work / Auto Accident/ Other Accident / Non-Accidental

If you circled "Work", please answer the following:

Employer at time of Injury _____ Work phone # () _____ Date of Injury _____
Workers' Compensation Insurance Name & Address _____
Name of Case Manager _____ Phone# () _____ Claim # _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured _____ Date of Birth _____
Social Security# _____ Relationship to Patient (Circle one) Self / Spouse / Parent / Guardian / Child / Other
Name of Employer _____ Work phone # () _____
Address of Employer _____ City _____ State _____ Zip _____
Name of Insurance _____ Insurance ID# _____
Insurance Group # _____ Union or local # _____ Insurance Phone # () _____
Insurance Company Address _____ City _____ State _____ Zip _____

Do you have Secondary Insurance? (Circle one) Yes No If yes, complete the following below

Name of Insured _____ Date of Birth _____
Social Security# _____ Relationship to Patient (Circle one) Self / Spouse / Parent / Guardian / Child / Other
Name of Employer _____ Work phone # () _____
Address of Employer _____ City _____ State _____ Zip _____
Name of Insurance _____ Insurance ID# _____
Insurance Group # _____ Union or local # _____ Insurance Phone # () _____
Insurance Company Address _____ City _____ State _____ Zip _____

AUTHORIZATION AND RELEASE/INSURANCE ASSIGNMENT

I hereby authorize and request my insurance company to pay directly to the Prosthetic and Orthotic Care, 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 prosthetic and orthotic 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 Prosthetic and Orthotic Care, 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 or benefits. We (Prosthetic and Orthotic Care, Inc.) have attempted to estimate your balance due. However, after review by your insurance company, you may owe an additional amount.

Signature of Beneficiary (or Parent/Spouse/Guardian)

Date

Signature of Representative (If Patient Is Unable To Sign)

Relationship to Patient