Patient Registration Form

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name?

Yes or No

If not, what is your legal name?

Social Security Number:

Birth date:

Age:

Sex:

M F

Address:____.

Street Address Apartment No./ P.O. Box City State Zip Code

Home/Cell phone Number: /	Occupation:
Other phone Number:	Employer:
Email Address:	Employer phone no.:

Is your visit related to an injury? Yes_______ No_________ If Yes, : WORK_________ AUTO________ OTHER ______

Claim Adjuster:______________________________

Phone Number:____________________________

Date Of Injury:____________________________

Referring Physician:_____________________________ Phone Number:_______________________

Have you received a similar device in the past? Yes ____ No ___ If Yes, When:______________ Insurance Coverage______________

Are you currently in a Medicare-covered bed at a skilled nursing facility? Yes____ No _____

Are you Diabetic: □ Yes □ No If yes, Diabetic Physician:_______________________________ Phone Number:________________

INSURANCE INFORMATION

(Please give your insurance card to the administrator.)

Guarantor:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:
Name of primary insurance:__________________ ____________________________ Policy ID:_________________________ _____ Subscriber's name:______________________ __________ Social Sec			

No.:__________________ Date of Birth:_________________

Patient's relationship to subscriber:_____________________

Name of secondary insurance (if applicable):___________________________________ Policy ID: __________________________

Subscriber's name:________________________________ Social Sec No.:___________________

Date of Birth:_______________ Patient's relationship to subscriber:_______________________

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home phone no.: Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Aspire Prosthetics & Orthotics or insurance company to release any information required to process my claims.

Patient/Guardian signature Relationship to Patient Date