

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____ SEX _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

SS# _____ MARITAL STATUS _____

SPOUSE NAME _____ SPOUSE SS# _____

IS THIS YOUR PERMANENT ADDRESS YES NO

HISTORY

TYPE OF INJURY OR ILLNESS _____ DATE OF ACCIDENT _____

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ PHONE # _____

ADDRESS _____ POLICY # _____

GROUP # _____ EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____ PHONE # _____

INSURED'S NAME _____ DATE OF BIRTH _____

SECONDARY INSURANCE _____ PHONE# _____

ADDRESS _____ POLICY# _____

GROUP # _____ EMPLOYER'S NAME _____

INSURED'S NAME _____ DATE OF BIRTH _____

SS# _____ EMPLOYER'S ADDRESS _____

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by ABC Prosthetics and Orthotics as prescribed by my physician. I also authorize the release of any medical or other information necessary to process this claim. I also request payment of government or insurance benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to ABC Prosthetics and Orthotics for services rendered. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance does not pay in a timely manner, or my physician or I fail to provide information necessary for payment in (30) thirty days. I hereby Authorize ABC Prosthetics and Orthotics to act as my agent and to accept the assignment of all of my insurance benefits to be paid, for services provided.

PATIENT SIGNATURE _____ DATE _____

IF MINOR PARENT OR GUARDIAN

RELATIONSHIP TO PATIENT _____ SS# _____

MEDICARE MEDICAID WORKER'S COMP AUTO PRIVATE PAY
INSURANCE