ABILITY PROSTHETICS & ORTHOTICS

PATIENT INFORMATION

Section 1

Patient Name: (Last, First, M) _____ Date of Birth: _____/_____/_____

Home Address: _____ APT#_____ City: _____ State: ___ Zip: _____

Home#:_____ Cell#:_____ EMAIL: _____

SSN: _____/_____/_____ Sex: M / F Marital Status: S□ M □ W□ Height: _____ Weight:_____

Referring Physician: _____ Reason for visit today? _____

How did you choose *ABILITY Prosthetics & Orthotics* to be your Orthotics-Prosthetics provider?

Section 2 – Spouse / Parent / Guardian / Responsible Party

Name: (Last, First, M) _____ SSN: _____/_____/_____ DOB: ____/_____/____

Relationship to Patient: Spouse / Parent / Guardian / Other (Explain):_____

Home#: _____ Cell#:_____ Work#:_____

Home Address: _____ APT#_____

City: _____ State: _____ Zip: _____ Home#:_____ Cell#:_____

Section 3 – Emergency Contact

Name: (Last, First, M): _____ Relationship: _____

Home#: _____ Cell#:_____ Work#:_____

Section 4 – Insurance Information

Primary Insurance: _____ ID#: _____

Policy Holder: _____ DOB: _____/_____/_____SSN: _____/_____/_____

Payer's Relationship to Patient: _____

Secondary Insurance: _____ ID#: _____

Policy Holder: _____ DOB: _____/_____/_____SSN: _____/_____/_____

I hereby request *ABILITY Prosthetics & Orthotics* to provide any prosthetics/orthotic services necessary, per my physician's prescription.

Patient's Signature: _____ Date: _____/_____/_____

Responsible Party: _____ Date: _____/_____/_____

Authorization of Benefits: I hereby authorize and assign payment of the benefits directly to *ABILITY Prosthetics & Orthotics*. I understand that I am financially responsible for non-covered services. I authorize *ABILITY Prosthetics & Orthotics* to release information to my physician and to my insurance carrier in order to process any insurance claim for services rendered. I also authorize *ABILITY Prosthetics & Orthotics* to contact my employer to verify my employment and insurance coverage. Divorced Parents: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all charges.