PATIENT REGISTRATION FORM

CREATIVE PROSTHETICS & ORTHOTICS, LLC

PATIENTS: PLEASE FILL OUT SECTIONS 1 AND 2 BELOW AND SIGN AND DATE.

PLEASE PRESENT *INSURANCE CARDS* AND *DRIVERS LICENSE* AT THE WINDOW WITH THIS FORM

1. *PATIENT INFORMATION* — ALL INFORMATION MUST BE COMPLETE

Social Security # of patient _____- _____ - _____ Patient's Date of Birth_____

Patient's FULL Name _____
LAST FIRST MI

Patient's Address: _____

City _____County_____ State _____ Zip _____

Home Phone: _____ Work Phone (Parents work phone if minor): _____

*Cell Phone #:_____ Marital Status: _____Single _____Married _____Divorced _____Other

EMAIL ADDRESS: _____

Sex: _____M _____F Height: _____ Weight: _____

Parent/Legal **Guardian**/Spouse: _____ Social security # _____

Guardian's Date of birth: _____ Employer: _____

Business Address: _____ Phone _____

PRESCRIBING PHYSICIAN _____

DIAGNOSIS_____ **DATE OF ONSET/INJURY** _____

DIABETIC TREATING PHYSICIAN_____

2. INSURANCE INFORMATION — *THIS INFORMATION MUST BE COMPLETED*

PRIMARY Insurance Carrier _____ Group Name/#_____

Certificate or ID#: _____ POLICY HOLDER'S NAME: _____

POLICY HOLDERS SS#: _____ **DOB**_____ Relationship to patient_____

SECONDARY Insurance Carrier _____ Group Name/#_____

Certificate or ID#: _____ POLICY HOLDER'S NAME: _____

POLICY HOLDERS SS#: _____ DOB_____ Relationship to patient_____

Authorization to Release Information to Necessary vendor/insurers to manufacture or bill required device.

I hereby authorize CREATIVE PROSTHETICS & ORTHOTICS, LLC to release only necessary information, including photographs, about me (patient) in order for my necessary and prescribed device(s) to be manufactured or reimbursed.

Authorization for Future Contact

I hereby authorize CREATIVE PROSTHETICS & ORTHOTICS, LLC to contact me at any time in the future to provide me with additional information to enhance the fit and function of my orthotic/prosthetic devices and treatment.

**** Authorization To Pay Benefits To CREATIVE P&O/Authorization to Release Information ****

I hereby authorize payment directly to CREATIVE PROSTHETICS & ORTHOTICS, LLC for any services I receive during my treatment. I give permission to CREATIVE PROSTHETICS & ORTHOTICS, LLC to release any information to my insurance company, attorney, assignees and/or beneficiaries.

**** Financial Responsibility - Cell Phone Permission****

The undersigned guarantees payment to CREATIVE PROSTHETICS & ORTHOTICS, LLC for services rendered in the event insurance does not cover all fees. I am responsible for payment if the insurance carrier decides this is a non-covered service or requires pre-authorization, which I did not obtain. *Permission hereby is granted to call my cell phone number.

MEDICARE PATIENTS:

I HAVE RECEIVED COPY (OR NOTICE) OF THE SUPPLIER STANDARDS_____
PATIENT/PARENT/LEGAL GUARDIAN/SPOUSE/ GUARANTOR

Signature: _____ Date: _____
PATIENT/PARENT/LEGAL GUARDIAN/SPOUSE/ GUARANTOR