GREEN PROSTHETICS & ORTHOTICS

Social Security #_____ First Name _____ Last Name_____

DOB: ____ / ____ /_____ Male/ Female (circle one) Marital Status: Married/Single/Other (circle one) Phone (____)_____

Patient Address: _____ City: _____ State: ____ Zip:_____ Cty: _____

Work Phone (___)_____Cell (____)_____Emergency Contact:_____Phone (____)_____

Patient Alt. Address:_____Phone: (____)_____ Email:_____
(PO Box or summer/winter residence if applicable)

RESPONSIBLE PARTY (If different than the patient - ex: parent of a dependent child)

Relationship to Patient _____ Social Security #: _____ DOB: ____ / ____ / ____

First Name _____ Last Name _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (____)_____Work Phone: (___) _____Cell Phone:(___)_____

INSURANCE INFORMATION Policy Holder's relationship to the patient: SELF SPOUSE PARENT/GUARDIAN

Primary Ins: _____

Policy Holder: _____DOB:_____

Address:_____

ID# _____Group# / Seq#_____

Secondary Ins: _____

Policy Holder: _____DOB: _____

Address: _____

ID# _____Group# / Seq#_____

REFERRAL INFORMATION

Prescribing Physician _____ Phone_____

Primary Care Physician _____ Phone_____

Physician Treating Diabetes_____Insulin___Non Insulin___ Phone_____

WORK COMP – AUTO INFORMATION

Insur. Carrier: _____ Employer: _____

Address: _____ City: _____ State: _____ Date of Injury: _____

Claim#: _____ Contact person: _____ Phone _____

Medical Supplier Standards, Hipaa Privacy Practices, Treatment/Medical Information Release & Acknowledgment of Financial Responsibility:

I authorize the release of any information to provide services or process claims. I request my insurance benefits, if any, be paid directly to the provider. As the responsible party I understand that I am personally responsible for the entire amount of my claim and that insurance benefits could be limited or non-existent. I understand Green Prosthetics & Orthotics Financial Facts, which explains payment policy and billing procedures. I agree to notify Green Prosthetics & Orthotics immediately of any change in insurance coverage or status.

I acknowledge that I have been notified where I can read and/or obtain the following: ABC CERTIFICATION , MEDICARE SUPPLIERS STANDARDS, PROTECTED HEALTH INFO (which includes HIPAA) while being treated by Green Prosthetics Orthotics.

Patient's Signature _____ **Date:** _____

*** INSURANCE AND PHOTO I.D. WILL BE SCANNED TO YOUR REGISTRATION***

Intake Updated:_____

Intake Updated:_____

OFFICE USE ONLY: Good Faith attempt was made to obtain acknowledgment of receipt of PHI_____

02/2012