Advanced Prosthetics & Orthotics

PATIENT REGISTRATION

PATIENT:____ (______) __________________
Last Name First Name M.I. Home Phone Number

Male or Female ( )
Date of Birth Social Security Number Cell Phone # E-mail Address

Home Address City State Zip

( )
If child, Please write Father's full name Phone Number If child, Please write Mother's full name

( )
Emergency Contact Relationship Address Phone

Employed/Student/Other Single Married Widower
Vocational Category (Circle one above) Driver's License # Marital Status (Circle one) Spouse's Name

( )
Employer Name/address (Street/City/State/Zip) Work Phone

( )
Primary Doctor's full name Phone Number Referring Doctor's full name Phone number

Do you Currently have A similar Device for what we are treating you today?

If yes? How old is it? _____ Where did you receive it? __________

ARE YOU DIABETIC? Yes [] No [] If so, DID YOU GET SHOES THIS YEAR?[]yes[]no

From Who? ________________ Name of Dr. treating Diabetes: ________________

INSURANCE INFORMATION

( )
Primary Insurance Company Name Street Address City Zip Phone

I.D. Number Group Number Plan Number Relationship to Insured Date of Birth

Secondary Insurance Company Name Street Address City Zip Phone

ID Number Group Number Plan Number Relationship to Insured Date of Birth
WORKER COMPENSATION RELATED? Yes ( ) No ( ) if so, Injury Date: ____________ Employer: ____________

( )
Insurance Company Name Address (Street/City/State/Zip) Phone Number

I authorize release of any information required to process all claims, as well as to effectively provide needed care. To do this, I permit photocopies of this authorization, and I hereby assign to APO benefit payment I am entitled to receive for services provided by APO. I understand that APO does not accept partial payment made by insurance carriers as full payment for the services rendered, and I will be responsible for any charges not covered by insurance. I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner. I understand this authorization is valid for the duration of my policy coverage. If I am a Medicare recipient, I request that payment of authorized Medicare benefits be made to me or on my behalf to APO for any services furnished to me by that provider. In addition, my signature below acknowledges the fact that I have received a copy of the Medicare Patient's Right and Supplier Standards. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I also understand if I am providing inaccurate information regarding the devices received and should Medicare/other insurance denied for same or similar received within 3- 5 years I will be responsible for payment. DATE:__________ ________________

Patient or Authorized Representative Signature: ________________________