CENTER FOR PROSTHETICS ORTHOTICS
PATIENT REGISTRATION FORM

Patient Name: _____
(Last) (First) (Middle Initial)

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address if different: _____

Cell: **( )** _____ E-Mail Address: _____Date of Birth: _____/_____/_____

SS#:_____/_____/_____ Marital Status: **S**_____ **M**_____ **W**_____ **Other** _____ Sex: **M** ____ **F** ____

Employer: _____ Work Phone: **( )** _____

Referring Dr.: _____ Primary Dr.: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: **( )** _____

Name: _____ Relationship: _____ Phone: **( )** _____

INSURANCE INFORMATION

***** PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST *****

If you are unable to show proof of insurance, you will be responsible for incurred charges

Current Insurance? Yes _____ No _____ **Primary Insurance:** _____
Policy/ID#: _____ **Group:** _____
Subscriber name: _____ **DOB:** _____/_____/_____ **SS#:**_____/_____/_____

I currently do not have insurance and will self-pay for my treatment. Yes _____ No _____

Are you currently residing in a Skilled Nursing Facility? **Yes ____** **No ____**
Are you currently residing in an Adult Family Home? **Yes ____** **No ____**

Name of Facility: _____ **Phone #: ( )** _____

****** TO OUR MEDICARE PATIENTS ******

Within the past five (5) years, have you received the same or similar item(s)? Yes_____No_____
If yes, please describe: _____
Date received: _____/_____/_____
If item was returned, please provide reason: _____
Date of return: _____/_____/____

PLEASE READ THE FOLLOWING, SIGN AND DATE BELOW:

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. I authorize my insurance benefits to be paid directly to Center for Prosthetics Orthotics. (further referred to as CPO). I also authorize CPO to release to my insurance carrier any information required for this claim.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CPO for any services furnished me by CPO. I further authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

The patient, if physically and mentally competent, must sign on their own behalf. If they cannot sign for themselves then a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of the signatory's authority should be stated; e.g., SS appointed, representative payee, court appointed guardian, etc…

Signature:_____ **DATE**:_____/_____/_____

Legally appointed guardian:

Name: _____ **Relationship to patient:** _____

Signature: _____ **Date:** _____/_____/_____

PLEASE BE SURE YOU HAVE ANSWERED ALL QUESTIONS.

THANK YOU!