WELCOME

PATIENT INFORMATION

NAME: _____
First Middle Last

ADDRESS: _____

_____
City State Zip

AGE: _____ BIRTH DATE: _____ SEX: M or F

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

SOCIAL SECURITY#: _____

PRIMARY INSURANCE

*Have you had any recent changes to your policy_____?

INSURANCE NAME: _____

INSURANCE ADDRESS: _____

_____
City State Zip

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S SS#: _____

SUBSCRIBER'S EMPLOYER: _____

POLICY OR ID #: _____

GROUP #: _____SUBSCRIBER'S DOB: _____

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____

CELL PHONE: _____

SECONDARY INSURANCE

INSURANCE NAME: _____

INSURANCE ADDRESS: _____

_____
City State Zip

SUBSCRIBER'S NAME: _____

POLICY OR ID #: _____

GROUP #: _____ SUBSCRIBER DOB: _____

WORK COMP/ AUTO ACCIDENT

DATE OF ACCIDENT: _____CLAIM#_____

INSURANCE COMPANY: _____

ADJUSTER_____
Name Number

EMPLOYER AT TIME OF INJURY_____

POWER OF ATTORNEY: YES or NO (Circle one)

If you have power of attorney over this patient, you must provide us with a copy of that document.

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized Medicare, Medicaid, or other private insurance benefits be paid directly to the above named company for any services furnished to me by that supplier. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid services, its agents, and Ability Prosthetics and Orthotics and information needed to determine these benefits payable to related services.

I have received the Notice of Privacy Practices and Medicare Supplier Standards.

_____ _____ _____
Signature of Patient (Parent/Guardian) Signature of Insured Date

_____ _____
Print Name if different from Patient Relationship to patient