PATIENT REGISTRATION

Patient name: _____ Date of birth: _____ ☐ Male ☐ Female

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

Cell phone #: _____ Home phone #: _____ Work phone #: _____

E-mail address: _____

Person(s) we are authorized to discuss your personal healthcare information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact: Name: _____

Relationship: _____ Phone Number: _____

MEDICAL INFORMATION

Height: _____ Weight: _____ Are you Diabetic: ☐ No ☐ Yes

If YES, who is the physician treating your diabetes? Name: _____ *(Must be an MD or DO)*

Last Visit Date with this Physician? _____ Phone: _____

Allergies to materials and/or chemicals, plastics, glue, etc.: _____

Have you ever worn an orthotic device/brace in the past? ☐ NO ☐ YES What type: _____ Year: _____

INSURANCE *(provide us your insurance card)*

Do you have a secondary insurance? ☐ NO ☐ YES *If yes, please be sure to provide both insurance cards.*

Primary Insurance: _____ Secondary Insurance: _____

Insurance Subscriber: ☐ Self If other, Name: _____ Date of birth: _____

AUTO OR WORKER'S COMPENSATION

Was this problem: **Related to an AUTO accident?** ☐ NO ☐ YES **WORK Accident?** ☐ NO ☐ YES

Date of injury / accident: _____ _ Auto/Workers Comp Carrier: _____

Claim ID #: _____

Claim adjuster name: _____ Phone #: _____

FINANCIAL RESPONSIBILITY NOTIFICATION

We will only notify you of your expected financial responsibility if you will owe $250 or more unless specifically requested.

HIPAA DOC / CONSENT TO TREAT

I, _____ *(print your name),* acknowledge receipt of and agree to the terms assigned within these three documents:

1) Medicare's 30 Supplier Standards
2) Consent to Treat and Assignment of Insurance Benefits for Union Orthotics & Prosthetics Co. and/or its subsidiary De La Torre Orthotics & Prosthetics
3) HIPAA Notice of Privacy Practices informing patients of their privacy rights regarding their medical and health information

Signature: _____ Date: _____

(Or Parent/Guardian Signature if patient is a minor)