PATIENT INFORMATION FORM

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (____) ____-_____ CELL: (____) ____-_____ WORK: (____) ____-_____

EMAIL ADDRESS:_____

DATE OF BIRTH: _____ HEIGHT:_____ WEIGHT:_____ SEX: _____

MARITAL STATUS:_____ SHOE SIZE: _____ SOCIAL SEC. #: _____

IS THE PATIENT ALLERGIC TO LATEX: YES NO

IS THE PATIENT DIABETIC: YES NO

REFERRING PHYSICIAN: _____ PH: _____

PRIMARY CARE PHYSICIAN: _____ PH: _____

****

EMPLOYER NAME: _____

****

TYPE OF INSURANCE: (CIRCLE ONE)

MEDICARE MEDICAID GROUP WORKERS COMP OTHER

NAME OF PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____ PH: _____

NAME OF SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____ PH: _____

PRIMARY STATE OF RESIDENCE (IF MEDICARE) _____

DO YOU HAVE ANY OTHER INSURANCE (OTHER THAN WHAT IS LISTED?) YES NO

NAME OF OTHER INSURANCE CARRIER & POLICY #: _____

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IS YOUR CONDITION THE RESULT OF AN ACCIDENT? YES NO

DATE OF INJURY (IF APPLICABLE) _____ ADJUSTER _____

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I UNDERSTAND THAT THIS COMPANY, AS A COURTESY TO ME, WILL MAKE EVERY REASONABLE EFFORT TO BILL ALL OF MY INSURANCE COMPANIES FOR PAYMENT ON MY ACCOUNT. I UNDERSTAND THAT ANY REMAINING BALANCE IS MY RESPONSIBILITY. IN THE EVENT THAT MY ACCOUNT IS PLACED WITH AN OUTSIDE COLLECTION AGENCY DUE TO NON-PAYMENT, I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES THAT MAY BE ADDED TO MY OUTSTANDING BALANCE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY ASSIGN ALL MEDICAL BENEFITS INCLUDING MAJOR MEDICAL, OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO THE ORTHOTIC & PROSTHETIC CENTER OF ST. PETERSBURG.

PATIENT SIGNATURE _____ DATE _____