CENTER FOR PROSTHETICS ORTHOTICS
PATIENT REGISTRATION FORM

Patient Name: _____
(LAST) *(FIRST)* *(MIDDLE INITIAL)*

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (*if different*): _____

Home Phone: ( ) _____ Cell: ( ) _____ Date of Birth: _____/_____/_____

SS#:_____ /_____ /_____ Marital Status: S_____ M_____ W_____ Other _____ Sex: M ____ F ____

Employer: _____ Work Phone: ( ) _____

Referring Dr.: _____ Primary Dr.: _____

E-Mail Address: _____

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 _____ Insurance Carrier: _____

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 a an Assisted Living or Group Home? Yes ____ No ____

Name of Facility: _____ Phone #: ( ) _____

Contact person at Facility: _____ Title: _____

*** Do you currently receive DSHS / Medicaid coupons for health care? Yes _____ No _____

*** If you DO NOT receive DSHS coupons, please read, sign and date the following ***

I am not receiving DSHS medical assistance and I agree to pay for services. If I later become eligible for DSHS medical assistance for the date of this service, I agree to notify the provider's billing office.

Signature: _____ Date: _____ /_____ /_____

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

Within the past five (5) years, have you received the same or similar items(s)?

Yes_____No_____

If yes, please describe: _____

Date received: _____/_____/_____

If item was returned, please provide reason: _____

Date of return: _____/_____/____

MEDICAL HISTORY

Please check all that apply:

☐ Your condition is a result of an accident from employment

☐ Your condition is a result of an auto accident

☐ Your condition is a result of another type of accident

General Health (please circle one): poor good excellent

Activity (please circle one): low medium high

Height: _____ ft _____ in

Weight: _____ lbs ☐ Recent changes in weight If so, how much: _____ lbs ☐ Plus ☐ Minus

Accident?

Date of Accident / Injury: _____

State Accident Occured: _____

Type of Accident: _____

☐ Congenital?

Have you had or do you have any of the following:

☐ HEART PROBLEMS	☐ HEPATITIS A OR B	☐ VISION PROBLEMS
☐ HYPERTENSION	☐ HIV POSITIVE	☐ PARKINSON DISEASE
☐ VASCULAR DISEASE	☐ RHEUMATOID ARTHRITIS	☐ ALZHEIMER DISEASE
☐ STROKE	☐ OBESITY	☐ PSYCHIATRIC PROBLEMS
☐ DIABETES	☐ OSTEOARTHRITIS	☐ ALCOHOLISM
☐ KIDNEY DISEASE	☐ PULMONARY DISEASE (TB)	☐ KNOWN ALLERGIES: _____

List any other conditions that you feel might affect your treatment (including dates and descriptions of surgeries):

_____

Currently taking any medications:

_____

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!

rev. 1/14/2011