Patient Information

Name_____ ☐Male ☐Female
First MI Last
Address_____
City _____ State _____ Zip _____
Home Phone (____)_____ Work / Mobile Phone (____)_____
Date of Birth ___/____/___ Age____ Social Security # _____

If Patient is a Minor- Responsible Party Info.

Name_____ ☐Male ☐ Female
Relationship to Patient_____
Address_____ City_____ State_____ Zip_____
Home Phone (___)_____ Work / Mobile Phone (____)_____
Date of Birth ____/____/____ Age ____ Social Security # _____

Are you a diabetic? ☐ Yes ☐ No
If yes, please provide name and phone number of physician treating your diabetes:
Name: _____ Phone # (____)_____

Is this a work related injury? ☐Yes ☐No
If yes, please provide your workers compensation claim information.

Prescribing physician: _____ Phone #(____)_____
Have you been fit with the same or similar item by any provider in the past 3 years.
☐Yes ☐No
If yes, provide date and provider _____

I authorize the release of any information necessary to provide services or process claims. As the responsible party I understand that I am responsible for the entire amount of my claim should my insurance benefits be limited or non-existent. I agree to notify the office if my insurance status changes.

Signed: _____ Date: _____

Please present the receptionist with your insurance card(s) so we may make copies.