**COMPREHENSIVE**
**PROSTHETICS & ORTHOTICS**

# LIABILITY / PERSONAL INJURY REGISTRATION

| **PATIENT INFORMATION**<br>NAME | ACCOUNT NUMBER |
|---|---|
| | |

| **RESPONSIBLE PARTY** *(person(s) allegedly responsible for your injuries)*<br>NAME | | | |
|---|---|---|---|
| | | | |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | | |
| NAME | | | |
| | | | |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | | |

| **ATTORNEY INFORMATION** *(Attorney representing your claim)*<br>NAME | | | PHONE NUMBER |
|---|---|---|---|
| | | | (  )  - |
| LAW FIRM | | | FACSIMILE NUMBER |
| | | | (  )  - |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | | |

| **ATTORNEY INFORMATION** *(Responsible Party's representation)*<br>NAME | | | PHONE NUMBER |
|---|---|---|---|
| | | | (  )  - |
| LAW FIRM | | | FACSIMILE NUMBER |
| | | | (  )  - |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | | |

Signature ______________________ Date ______________________

Representative's Signature ______________________ Date ______________________

Representative's Printed Name ______________________

Relationship to Patient ______________________

*In the event your medical claims are to be submitted to a group health plan for injuries sustained in a work related injury you may be responsible for deductibles, co-payments or coinsurance, depending upon the plan design.*