COMPREHENSIVE
PROSTHETICS & ORTHOTICS

PATIENT REGISTRATION FORM

DATE: ___________________

Please **PRINT LEGIBLY** and make sure you complete all information on this form. Upon completion, please give to the Front Desk Receptionist with your Insurance Card(s) and Photo Id.

LAST NAME	FIRST NAME	MIDDLE NAME	NICKNAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	EMAIL ADDRESS
/ /	☐ Male ☐ Female	- -	

VOCATIONAL CATEGORY – EMPLOYMENT INFORMATION

☐ Full Time ☐ Part Time

☐ Employed ☐ Student ☐ Homemaker ☐ Disability ☐ Unemployed ☐ Retired

DRIVERS LICENSE NUMBER	MARITAL STATUS (check one)	LANGUAGE
	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	

HOME PHONE	WORK PHONE	CELL PHONE
( ) -	( ) -	( ) -

HOME ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER

EMPLOYER ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

Are you currently staying in a Nursing Facility (Temporary or Permanently)?	☐ Yes	☐ No
Is this a Worker's Compensation Claim? (check one)	☐ Yes	☐ No
Is your condition a result of an accident from employment?	☐ Yes	☐ No
Is your condition a result of an auto accident?	☐ Yes	☐ No
Is your condition a result of any other type of accident?	☐ Yes	☐ No

Date of Accident / /

PRIMARY INSURANCE COMPANY

BILLING ADDRESS	CITY	STATE	ZIP

PHONE NUMBER	ID#	GROUP #	PLAN #
( ) -			

INSURED'S NAME	INSURED'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
	/ /	☐ Self ☐ Spouse ☐ Other

SUPPLEMENTAL INSURANCE COMPANY

BILLING ADDRESS	CITY	STATE	ZIP

PHONE NUMBER	ID#	GROUP #	PLAN #
( ) -			

INSURED'S NAME	INSURED'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
	/ /	☐ Self ☐ Spouse ☐ Other

The above information is true to the best of my knowledge. I understand that I am financially responsible for supplies and services received.

Signature: ____ Date:______________________

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PATIENT REGISTRATION FORM

DATE: ____________________

INTERNAL OFFICE USE ONLY		
☐	Demographics Complete	Patient Information / General Info Tab
☐	Scan Patient Identification	Patient Information / General Info Tab
☐	Medical History	Medical HX / Administrative Documents
☐	Patient Consent & Acknowledgement Form Received & Scanned to Admin Documents	HIPAA Docs & Supplier Standards / Administrative Documents
☐	HIPAA Signatures Received / Recorded	HIPAA Docs & Supplier Standards / Administrative Documents
☐	Supplier Standards Signature Received / Recorded	HIPAA Docs & Supplier Standards / Administrative Documents
☐	Scan Patient Intake Documents	Scanned Documents Form / Administrative Documents Folder
☐	Start Up Prescription Received & Scanned	Patient Information / Prescriptions Tab
☐	Detailed Prescription Submitted to Referring Physician	Detailed Prescription / Initial Evaluation
☐	Diabetic Verification Submitted to Primary Care Physician	Diabetic Verification Form / Initial Evaluation
☐	Insurance Verification Completed	Insurance Ver v3.0 / Administrative Documents
☐	Insurance Authorization Completed	Insurance Auth v2.0 / Administrative Documents
☐	Service Estimate Created	Service Estimate / Administrative Documents
☐	Financial Responsibility / Counseling Completed	Financial Responsibility / Administrative Documents
☐	Release Orders in Purchasing System	OPIE Lite & FAB Tracking