EAST TEXAS PROSTHETIC ORTHOTIC CARE, INC.

PATIENT REGISTRATION FORM

1. PATIENT INFORMATION

DATE: _____

LAST NAME | FIRST NAME | MI | HM PHONE | CELL PHONE

PERMANENT ADDRESS | CITY | STATE | ZIP

M/F | DATE OF BIRTH | SSN | REFERRING PHYSICIAN NAME

EMAIL ADDRESS | EMERGENCY CONTACT NAME & PHONE NUMBER

2. INSURED PARTY/PARENT OR GUARANTOR INFORMATION

LAST NAME | FIRST NAME | MI | RELATIONSHIP TO PT | DATE OF BIRTH

EMPLOYER | PHONE | HOW LONG EMPLOYED?

SPOUSE NAME | SSN | DATE OF BIRTH

SPOUSE'S EMPLOYER | PHONE | HOW LONG EMPLOYED?

3. INSURANCE INFORMATION

MEDICARE NUMBER | INSURANCE COMPANY

MEDICAID NUMBER | GROUP NUMBER

PVT INS OR SUPPLEMENT POLICY | EMPLOYER/GROUP NAME

4. WORKERS COMPENSATION INFORMATION

INSURANCE CARRIER | PHONE | ADJUSTER NAME

ADDRESS | CITY | STATE | ZIP

CLAIM NUMBER | DATE OF INJURY

FINANCIAL NOTICE AND AUTHORIZATION OF TREATMENT

I understand that I am personally responsible for payment of services not covered by my insurance company as well as co-insurance and deductible amounts at the time services are rendered. I hereby authorize treatment for Orthotic and/or prosthetic services for the above named patient when prescribed by a physician. I also understand that I must pay a $65.00 office visit fee payable prior to my evaluation/consultation. ETPOC is not considered a physician's office and therefore this fee will not be billable to my insurance company and is due at the time of my evaluation.

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**