VIPO Valley Institute of Prosthetics and Orthotics, Inc.

PATIENT REGISTRATION

PLEASE COMPLETE ENTIRE FORM

TODAY'S DATE:	PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN:

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I.:	NICK NAME

DATE OF BIRTH:	GENDER	SOCIAL SECURITY NUMBER:	EMAIL ADDRESS:
/ /	☐ MALE ☐ FEMALE	- -	

MARITAL STATUS	CELL PHONE:	HOME PHONE:
☐ S ☐ M ☐ D ☐ W ☐ OTHER	( )	( )

EMP. STATUS:	EMPLOYER - NAME OF COMPANY:	WORK PHONE: EXT#	LANGUAGE PREF.
☐FT ☐PT ☐Unemp		( )	☐Eng ☐Span ☐_____

HOME ADDRESS (NUMBER & STREET)	CITY	ST	ZIP CODE

MAILING ADDRESS (IF DIFFERENT)	CITY	ST	ZIP CODE

SPOUSE/PARTNER'S NAME:	SPOUSE/PARTNER'S EMPLOYER:	SPOUSE/PARTNER DAYTIME PHONE:
		( )

OTHER EMERGENCY CONTACT - NAME:	RELATIONSHIP:	EMERGENCY CONTACT PHONE:
		( )

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) *REQUIRED FOR MINOR CHILD*

CHECK BOX TO DESIGNATE RELATIONSHIP OF RESPONSIBLE PARTY

☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN ☐ SPOUSE ☐ OTHER_____

LAST NAME:	FIRST NAME:	M.I.	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
			/ /	- -

HOME PHONE:	WORK PHONE:	CELL PHONE:
( )	( )	( )

PERMANENT MAILING ADDRESS:	CITY:	STATE	ZIP:

INSURANCE INFORMATION *PLEASE PROVIDE INSURANCE CARD(S) TO RECEPTIONIST*

PRIMARY INSURANCE NAME:	SUBSCRIBER NAME:

SUBSCRIBER BIRTHDATE:	SUBSCRIBER I.D. NUMBER:	GROUP NUMBER:
/ /		

SECONDARY INSURANCE NAME:	SUBSCRIBER NAME:

SUBSCRIBER BIRTHDATE:	SUBSCRIBER I.D. NUMBER:	GROUP NUMBER:
/ /		

☐ **I HAVE NO OTHER INSURANCE** *If tertiary (third) insurance, please provide insurance card to receptionist)*

IMPORTANT QUESTIONS:

1. Have you ever received the same or similar item from another provider before? ☐NO ☐YES **If so, WHEN?**

2. Are you here because of a work-related injury or automobile accident? ☐ NO ☐ YES, **DATE OF INJURY:** / /

3. If you have Medicare B, is the patient home address provided above your permanent residence? ☐ NO ☐ YES

If this is not your permanent address, do you reside there more than 6 months per year? ☐ NO ☐ YES

4. Please check ✓ if you are ALLERGIC to ☐ **NEOPRENE** ☐ **LATEX**

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the insurance carrier(s)/third party payor(s) referenced above to pay **VALLEY INSTITUTE OF PROSTHETICS AND ORTHOTICS, INC.** (VIPO) directly for medical supplies or service benefits, if any, otherwise payable to me, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not covered by my insurance company. I hereby authorize the release of my medical information necessary for my insurance to process all claims submitted by **VIPO** on my behalf.

▶ _____ ▶ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**