VIPO Valley Institute of Prosthetics and Orthotics, Inc.

PATIENT REGISTRATION

PLEASE COMPLETE ENTIRE FORM

DATE: ____________ PRIMARY CARE PHYSICIAN ____________ REFERRING PHYSICIAN: ____________

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I.:

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

HOME ADDRESS:	CITY:	STATE	ZIP:

DATE OF BIRTH:	AGE		SOCIAL SECURITY NUMBER:
/ /		☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE	- -

EMPLOYER - NAME OF COMPANY:	EMPLOYER PHONE:
	( )

EMPLOYER ADDRESS:	CITY:	STATE	ZIP:

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

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

PRIMARY INSURANCE NAME:	SUBSCRIBER NAME:

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

SECONDARY INSURANCE NAME:	SUBSCRIBER NAME:

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

☐ **I HAVE NO OTHER INSURANCE**

IMPORTANT QUESTIONS:

1. How did you learn about VIPO? ☐ **My doctor** ☐ **Yellowpages** ☐ **Friend** ☐ **Internet** ☐ **Other:**

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? ☐ **YES** ☐ **NO**

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

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 to process all claims submitted by **VIPO** on my behalf.

► ____________________ ► ____________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE