

PATIENT REGISTRATION

PLEASE COMPLETE ENTIRE FORM

TODAY'S DATE:	PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN:
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PATIENT INFORMATION

LAST NAME:		FIRST NAME:		M.I.:	NICK NAME
DATE OF BIRTH: / /		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		SOCIAL SECURITY NUMBER: - -	
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> OTHER		CELL PHONE: ()		HOME PHONE: ()	
EMP. STATUS: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemp	EMPLOYER - NAME OF COMPANY:		WORK PHONE: ()		EXT#
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