REGISTRATION FORM

(Please Print)

Today's date:					
PATIENT INFORMATION					
Patient's last name: First: Middle:			Nickname:	Date of birth: / /	Gender: ❑ M ❑ F
SSN:	Email address:		Employment status: ❑Emp F/T ❑Emp P/T ❑ Student ❑Unemp❑Retired		
Driver's license number: (Please give DL to the receptionist.)		Marital status: ❑Single ❑Married ❑Divorced ❑Widow ❑ Other		Home phone: ( )	
Cell phone: ( )		Other phone: (Please specify) ( )		Employer phone: ( )	
Home address:		City:		State:	ZIP:
Employer:	Employer address:		City:	State:	ZIP:
IN CASE OF EMERGENCY					
Name:	Relationship to patient:		Home phone: ( )	Work phone: ( )	
Other contacts: (Therapist/School/Case Mgr) Name:	Relationship to patient:		Home phone: ( )	Work phone: ( )	
SKILLED NURSING FACILITY					
SNF Name:		Phone: ( )			
SNF address:		City:		State:	ZIP:

PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance company name:	Address:	City:	State:	ZIP:	Phone no.: ( )

Subscriber's name: (if different from pt)	ID#:	Group #:	Plan #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Subscriber info (if different from patient): Employer:	Date of Birth: / /	Gender ❑ M ❑ F	SSN:

Subscriber address:	City: ZIP:	State:	Phone: ( )

SECONDARY INSURANCE INFORMATION

Secondary Insurance company name:	Address:	City:	State:	ZIP:	Phone no.: ( )

Subscriber's name: (if different from pt)	ID#:	Group #:	Plan #:

Subscriber info (if different from patient): Employer:	Date of Birth: / /	Gender ❑ M ❑ F	SSN:

Subscriber address:	City: ZIP:	State:	Phone: ( )

PHYSICIAN INFORMATION

Reason for visit:	Accident date:	Rx date: / /	Diagnosis (if known)

Referring Physician name:	Address:	City:	State:	ZIP:	Phone no.: ( )

Primary Care Physician (PCP) name:	Address:	City:	State:	ZIP:	Phone no.: ( )

PLEASE READ, SIGN, AND DATE

Optimus Prosthetics agrees to bill most insurance carriers if all necessary information is provided.

I, the patient or legal representative, agree to be financially responsible for all charges whether or not paid for by insurance.
I assign to Optimus Prosthetics, permission to bill my insurance company and release information pertaining to claim submittal.

Patient/Guardian signature *Date*

***Latex allergy? ❑ Yes ❑ No