PONGRATZ ORTHOTICS & PROSTHETICS, INC.

PATIENT REGISTRATION FORM

Today's Date: _____ Referring Doctor: _____
Phone: _____

♣PATIENT INFORMATION:

Name: _____ Birthdate: _____ Age: _____
Last First M.I

Address: _____ Social Security #: _____
Street Number and Name

_____ Email: _____
City State Zip Code

Phone: ( ) _____ Sex ___Male ___Female

Marital Status: Single ___ Married ___ Widow ___ Divorced ___
___Other

Are you a diabetic? ___YES ___NO If YES, which physician treats your diabetes: _____

Are you a resident in a Skilled Nursing Facility/Assisted Living Facility/Specialty Hospital? ___YES ___NO

♣NAME OF RESPONSIBLE PARTY:

Name: _____ Birthdate: _____ Age: _____
Last First M.I

Address: _____ Social Security #: _____
Street Number and Name

_____
City State Zip Code

Phone: ( ) _____

Relation to patient: ___Self ___Spouse ___Child ___Other

Employer: _____ Employer Phone: _____
Employer Address: _____
_____

♣INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Ins. Co. Name:	Ins. Co. Name:
Address:	Address:
Phone:	Phone:
Policy Holder Name:	Policy Holder Name:
Address:	Address:
Policy #	Policy #
Group #	Group #
Claim #	Claim #

♣NATURE OF INCIDENT:

Accident: _____Yes _____No
_____Auto _____Employment _____Other

Date of Injury: _____
Claim No.: _____
Claim Adjuster: _____

AUTHORIZATION:

I hereby authorize the release of information regarding my/the patient's condition/treatment, as necessary to process this and/or related claims. **I understand that I am responsible for all fees not covered by insurance, Medicare, Medical Assistance or other Governmental Agencies, or Worker's Compensation.**

Signature: _____ **Date:** _____
CIRCLE ONE: PATIENT OR RESPONSIBLE PARTY