Patient Information:

(Last/First):_____ Sex:_____
Address:_____ City:_____
State:_____ Zip:_____ Home#:_____ Work:_____
SS#:_____ DOB:_____ Age:_____
Height:_____ Weight:_____ Married:____ Single:____ Widowed:____ Divorced: ____

Are you diabetic? Y / N
If so, who is your treating physician? _____

Are you currently "<u>inpatient status</u>" in a nursing home or skilled nursing facility? **Yes ☐ No ☐**

Insured Member (if different from patient)

(Last,First):_____ Sex:_____
Address:_____ City:_____
State:_____ Zip:_____ Home#:_____ Work:_____
SS#:_____ DOB:_____ Age:_____

Insurance Information

Primary Ins:_____ Phone:_____
Group#:_____ ID#:_____
Secondary Ins.:_____ Phone:_____
Group#:_____ ID#:_____

Referral Information

Prescribing MD:_____ Phone:_____
Primary Care Physician:_____ Phone:_____

Work Comp Information

Insurance Carrier:_____ Employer:_____
Address:_____
Date of Injury:_____ Case/Claim#:_____ Adjuster:_____

Emergency Contact

Name:_____ Relationship:_____
Phone#:_____

Other Information

Diagnosis:_____
Other Conditions:_____ Date of Surgery:_____

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsibility party I am personally responsible for the entire amount of my claim and the insurance benefits may be limited or non-existent. I agree to notify **Carolina Orthotics & Prosthetics** immediately of any change in insurance coverage or status.

Signed:_____ Date:_____