

Evergreen Prosthetics & Orthotics, LLC

Patient Registration

Patient Name (First, Middle Initial, Last Name):

Address: _____ City/State/Zip:

Phone: _____ Cell No: _____ Wk No:

Sex: _____ Date of Birth: _____ SS No: _____ Employer:

Are you diabetic? _____ **Shoe Size:** _____ **Height:** _____
Weight: _____

Emergency/Alternate Contact(s)

Name, Relationship & Number:

Primary Care Physician (Name & Phone Number): _____

Referring Physician (Name & Phone Number): _____

Insurance Information

Primary Insurance

Carrier Name of Insurance Co.: _____ ID:

Group Name/Employer: _____ Group No.:

Subscriber Name (if other than patient): _____ Subscriber Date of Birth: _____

Secondary Insurance

Carrier Name of Insurance Co.: _____ ID:

Group Name/Employer: _____ Group No.:

Subscriber Name (if other than patient): _____ Subscriber Date of Birth: _____

Please ONLY complete this section if your injury is related to the following.

Work Injury / Motor Vehicle Accident / Other Liability (Please circle one.)

Carrier Name: _____ Claim No.:

Date of Injury/Accident: _____ Adjuster Name & Phone No.:

If work Injury: Employer Name & Phone Number @ Time of Injury:

If motor vehicle accident: Policy Holder Name & Phone No.:

Assignment of Benefits & Notice of Financial Responsibility:

I authorize Evergreen Prosthetics & Orthotics, LLC to bill my insurance for payment of services rendered. Any quote of coverage or potential financial responsibility given by an Evergreen employee is not a guarantee and is subject to change and will ultimately be based on the processing by your insurance provider. I agree to provide Evergreen Prosthetics & Orthotics, LLC with my correct billing and contact information or I may be responsible for any balance(s) incurred. I agree that any returned checks will accrue a charge of \$25 for each occurrence. I understand that I am ultimately responsible for the balance of my account and agree to pay in a timely manner.

Guardian/Legal Representative Signature:

Relationship to Patient: _____ **Date:**

Patient Signature: _____ **Date:**

Effective 09/01/2010