P&O Associates -- PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____

Date of Birth: __ __ / __ __ / __ __ __ __ Sex: M F Marital Status: M S D Other _____

Social Security # __ __ __ - __ __ - __ __ __ __ Email Address: _____

Home PH: ( ) __ __ __ - __ __ __ __ Work PH: ( ) __ __ __ - __ __ __ __ Cell PH: ( ) __ __ __ - __ __ __ __

Mailing Address: _____

City: _____ State: _____ Zip: __ __ __ __ __ - __ __ __ __

Prescribing DR: _____ PH: ( ) __ __ __ - __ __ __ __ FX: ( ) __ __ __ - __ __ __ __

Primary Care DR: _____ PH: ( ) __ __ __ - __ __ __ __ FX: ( ) __ __ __ - __ __ __ __

Emergency Contact: _____ Relationship: _____ PH: ( ) __ __ __ - __ __ __ __

How did you hear about P&O Associates?: _____

PRIMARY INSURANCE: _____ **ID #** _____

Insurance Phone Number: ( ) __ __ __ - __ __ __ __ Contact: _____

Patient's Relationship to Subscriber: Self Spouse Dependent Other _____

Subscriber's Name: _____ SSN: __ __ __ - __ __ - __ __ __ __

Address (if different from patient): _____

_____

Date of Birth: __ __ / __ __ / __ __ __ __ Home Phone: ( ) __ __ __ - __ __ __ __

Employer: _____ Phone: ( ) __ __ __ - __ __ __ __

SECOND INSURANCE: _____ **ID #** _____

Insurance phone number: ( ) __ __ __ - __ __ __ __ Contact: _____

Patient's Relationship to Subscriber: Self Spouse Dependent Other _____

Subscriber's Name: _____ SSN: __ __ __ - __ __ - __ __ __ __

Address (if different from patient): _____

_____

Date of Birth: __ __ / __ __ / __ __ __ __ Home Phone: ( ) __ __ __ - __ __ __ __

Employer: _____ Phone: ( ) __ __ __ - __ __ __ __

COVERED BY WORKMANS COMPENSATION? Yes No Claim # _____

Workmans Comp Carrier: _____ PH: ( ) __ __ __ - __ __ __ __

Address: _____

Case Manager: _____ PH: ( ) __ __ __ - __ __ __ __ FX: ( ) __ __ __ - __ __ __ __

Attorney: _____ PH: ( ) __ __ __ - __ __ __ __ FX: ( ) __ __ __ - __ __ __ __

I, the undersigned, do hereby agree and give my consent for Prosthetic & Orthotic Assoc., Inc. (POA) to furnish medical care and treatment to me (or my dependant). I also certify that I (or my dependent) have insurance coverage as indicated above and assign directly to POA all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize POA to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Patient/Guardian/Representative Signature Printed Name and Relationship Date