YAKIMA ORTHOTICS & PROSTHETICS, PC

PATIENT INFORMATION:

Todays Date: _____ Age: _____ Male:_____ Female: _____

Patient Name: _____ Date of Birth: _____

Mailing address: _____ Home Phone: _____

_____ Work Phone:_____

_____ Cell Phone: _____

RESPONSIBLE PARTY:

Bill to :_____ Relationship to patient: _____

Bill to address: _____ SSN: _____

_____

Name of Employer or School: _____Phone: _____

INSURANCE INFORMATION:

It is your responsibility to provide our office with your current insurance information. Please present your insurance information at every visit, and promptly notify us of any changes in your eligibility.

Primary:_____ Secondary: _____

Subscriber:_____ DOB:_____ Subscriber: _____ DOB: _____

ID #: _____ ID #: _____

Group #: _____ Group #: _____

Subscriber's Employer: _____ Subscriber's Employer: _____

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare benefits be made to YAKIMA ORTHOTICS & PROSTHETICS, PC for any services furnished to me by the supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary: _____ HICN: _____

Signature: _____ Item: _____

Date : _____

OTHER INSURANCE:

Is this a work related claim: Y or N DOI: _____ Claim #: _____

Is this a Auto Accident Claim: Y or N DOI: _____ Claim #: _____

Name of Insurance company: _____

Claim Manager Name: _____ Phone #: _____

MEDICAL INFORMATION:

Primary Doctor: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

Physical Therapist: _____ Phone #: _____