PATIENT REGISTRATION FORM
Height and Weight: _____

Streamline
ORTHOTICS + PROSTHETICS

PATIENT INFORMATION

Name: (Last, First, MI) _____ Date of Birth: _____/_____/_____

Social Security #_____ Weight: _____lbs. Gender: ☐ M ☐ F
Street Address: _____City: _____ Apartment # _____
State: _____ Zip Code: _____
Phone _____ _____

Email: _____
Guardian (financially responsible person) Name: _____
Referring Physician/Pediatrician Name: _____ Phone _____
In case of emergency contact Name: _____ Phone_____

☐ (initial) Consent to contact you at all numbers listed above and leave a message regarding orthotic/prosthetic needs
☐ (initial) Consent to text appointment reminders or other patient care information
☐ (initial) Consent to use email as a communication form for appointments and patient care

INSURANCE POLICIES

Primary Insurance: _____ Policy ID# _____

Policy Holder Name: _____ Date of Birth: ____/_____/_____

Secondary Insurance: _____ Policy ID# _____

Policy Holder Name: _____

IS THIS VISIT RELATED TO WORKER'S COMPENSATION INJURY? ☐ YES ☐ NO
*If yes, please ask our office for our Worker's Compensation Form to include the necessary information.
HAVE YOU RECEIVED A SAME/SIMILAR DEVICE? ☐ YES ☐ NO

By signing below I acknowledge the above information is correct and agree to the following statements:

Benefits, Medical Information Release Authorization and Acknowledgement of Financial Responsibility:
I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information. 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 responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non- existent.

Medicare Lifetime Signature on File
I request that payment of authorized Medicare benefits be made on my behalf to Streamline Orthotics and Prosthetics for any services provided to me. 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 benefits payable for related services.

_____ _____
Signature of Patient or Guardian/ Authorized Representative *Date*

_____ _____
Printed Name of Above *Relationship to patient*