ACTION BRACE AND PROSTHETIC, INC.

Please print

PATIENT INFORMATION

Last Name ____ First Name ____ M.I. ____ Social Security Number ____

Street Address ____ City ____ State ____ Zip ____ (____) Home Phone Number

Employer ____ (____) Work Phone Number

Date of Birth ____ M / F Sex Single / Married / Divorced / Widowed Marital Status (____) Cell phone or pager

Person to notify in case of an EMERGENCY ____ Relationship ____ (____) Phone Number

Referring Physician ____ (____) Phone Number

Are you being treated for diabetes? Yes or No   If yes, please provide name and phone # of your diabetic doctor below

Diabetic Doctor ____ **Insulin Dependent? Yes or No** (____) Phone Number

Is injury related to any of the following: AUTOMOBILE ACCIDENT / WORK INJURY / N/A

If the above is applicable: DATE OF ACCIDENT. ____ Employer at time of injury ____ Claim Number ____

Case Manager ____ (____) Phone Number

RESPONSIBILE PARTY

If other than the **PATIENT**, please fill out this section.

Last Name ____ First Name ____ M.I. ____ Relationship to Patient ____ Social Security Number ____

Street Address ____ City ____ State ____ Zip ____ (____) Home Phone Number

Employer ____ (____) Work Phone Number

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Policyholder / Birthdate	Name of Policyholder / Birthdate
Insurance Company	Insurance Company
Insurance Company Phone Number	Insurance Company Phone Number
Identification Number	Identification Number
Plan or Group Number	Plan or Group Number

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND INFORMATION AUTHORIZATION

I hereby authorize **ACTION BRACE AND PROSTHETIC, INC.** to furnish information to insurance carriers concerning my illness and treatment and hereby assign to **ACTION BRACE AND PROSTHETIC, INC.** all payments for services furnished to me. I understand that I am responsible for all charges, even those not paid by insurance. When full payment of your account is made, at the time of service, we will instruct your insurance carrier to send payments directly to you. My signature to this document may be used as the “Signature on File” for the appropriate billing to a third-party payer.

SIGNATURE ____ **DATE** ____