PATIENT REGISTRATION

Patient's Name:_____ **Birthdate** _____ ☐ Female
Last First MI

Address: _____ ☐ Male
Street City State Zip

Social Security # _____ **Phone** (____) _____ **Cell** (____) _____

Email address: _____ Only for use by Riverside Orthotics and Prosthetics

Name of Responsible Party_____ Relationship_____

Employer _____ Work Phone (____) _____

Emergency Contact_____ Phone (____) _____

INSURANCE INFORMATION

Primary Insurance_____ Secondary Insurance_____

Policy # _____ Group# _____ Policy # _____ Group# _____

Policy Holder _____ Policy Holder _____

Birthdate of Policy Holder _____ Birthdate of Policy Holder _____

PLEASE PRESENT COPY OF INSURANCE CARDS TO RECEPTIONIST

PHYSICIAN INFORMATION

Who is the Patients Primary Physician?_____ Phone (____) _____

Who is the Patient's Medical Specialist?_____ Phone (____) _____

Are you a Diabetic? YES / NO Doctor who treats your Diabetes?_____

How did you hear about us?_____

AUTHORIZATION

I hereby authorize the release of information regarding my condition/treatment, as necessary, to process these and/or related claims. I understand that I am responsible for all fees not covered by insurance, Medicare, Medical Assistance or other Government Agencies or Worker's Compensation.

Signature _____ Date_____
Patient or Responsible Party