Patient Registration

Patient Name (First, Middle Initial, Last): _____

Address: _____

City / State / Zip: _____

Home Phone: _____ Cell No: _____ Work No: _____

Sex: _____ Date of Birth: _____ SS No: _____ Employer: _____

Guarantor Name _____ Patient relationship to Guarantor: **Self Spouse Child Other**

Guarantor Address _____ Telephone: _____

Are you diabetic? _____ **Shoe size:** _____ **Height** _____ **Weight:** _____

Emergency / Alternate Care Contact(s)

Name, Relationship & Phone Number: _____

Primary Care Physician (Name & Phone Number): _____

Referring Physician (Name & Phone Number): _____

Primary Insurance

Carrier Name of Insurance Co.: _____ ID: _____

Group Name / Employer: _____ Group No.: _____

Subscriber Name (if other than patient): _____ Subscriber Date of Birth: _____

Relationship to Insured _____

Secondary Insurance

Carrier Name of Insurance Co.: _____ ID: _____

Group Name / Employer: _____ Group No.: _____

Subscriber Name (if other than patient): _____ Subscriber Date of Birth: _____

Relationship to Insured _____

Please ONLY complete this section if your injury is related to the following.

Work Injury / Motor Vehicle Accident / Other Liability (Please circle one.)

Carrier Name: _____ Claim No.: _____

Date of Injury/Accident: _____ Adjuster Name & Phone No.: _____

If Work Injury: Employer Name & Phone Number @ Time of Injury: _____

If motor vehicle accident: Policy Holder Name & Phone No.: _____

Assignment of Benefits & Notice of Financial Responsibility:

I authorize Oregon Orthotic Services, Inc. to bill my insurance for payment of services rendered. Any quote of coverage or potential financial responsibility given by an Oregon Orthotic Services, Inc. employee is not a guarantee and is subject to change and will ultimately be based on the processing by your insurance provider. I agree to provide Oregon Orthotic Services, Inc. with my correct billing and contact information or I may be responsible for any balance(s) incurred. I agree that any returned checks will accrue a charge of $35 for each occurrence. I understand that I am ultimately responsible for the balance of my account, and agree to pay in a timely manner. By signing below I acknowledge that I have read, received, and understand the financial policy given to me by Oregon Orthotic Services, Inc.

Guardian / Legal Representative Signature: _____

Relationship to Patient: _____ **Date:** _____

Patient Signature: _____ **Date:** _____