

Orthotic Solutions Patient Registration

Date: _____

Patient Name: _____
Date of Birth: _____ / _____ / _____ Age: _____ Social Security Number _____ - _____ - _____ Sex: Male / Female
Address: _____
City: _____ State: _____ Zip: _____ Home Phone #: _____ Cell Phone #: _____
Employed: Yes / No Employer/School Name: _____ Occupation: _____
Employer Address: _____ Employer Phone #: (_____) _____ - _____
Best Number to contact: Home Cell Work

AILMENT INFORMATION

Date of Onset _____ Diagnosis _____
Diabetic: Yes / No Is this related to your employment: Yes / No
Current Medications: _____
Latex Allergy: Yes / No Other Allergies: _____

EXTENDED INFORMATION

Person Financially Responsible for the Bill _____ SSN #: _____ - _____ - _____
Billing Address _____ Date of Birth: _____ / _____ / _____
Relationship to Patient: _____ Cell #: _____ Home #: _____ Work #: _____
Best Number to contact: Home Cell Work
Employer Name: _____ Employer Address: _____
Other Parent's Name: _____ Cell#: _____ Home#: _____ Work#: _____
Best Number to contact: Home Cell Work
Referred by: _____ Phone #: _____ Family Physician: _____ Phone #: _____
Person to Notify in Case of Emergency _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company _____ Phone # _____
Plan Address _____ ID # _____
City _____ State _____ Zip _____ Group #/Name _____
Insured Name _____ Sex: Male / Female Date of Birth _____ / _____ / _____
Policy Holder's Address _____ Phone # _____
City _____ State _____ Zip _____ SS# _____ - _____ - _____
Policy Holder's Employer _____ Employers Insurance Plan: Yes / No
Relationship of Patient to the Policy Holder: SELF HUSBAND WIFE CHILD PARENT OTHER

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company _____ Phone # _____
Plan Address _____ ID # _____
City _____ State _____ Zip _____ Group #/Name _____
Insured Name _____ Sex: Male / Female Date of Birth _____ / _____ / _____
Policy Holder's Address _____ Phone # _____
City _____ State _____ Zip _____ SS# _____ - _____ - _____
Policy Holder's Employer _____ Employers Insurance Plan: Yes / No
Relationship of Patient to the Policy Holder: SELF HUSBAND WIFE CHILD PARENT OTHER