Orthotic Solutions
Patient Registration

Date: _____

Patient Name: _____ (Last / First / MI)
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Sex (M/F):_____
Social Security Number: _____ - _____ - _____

Primary Phone #: _____ cell / home / work (please circle)
Alternate Phone #:_____ cell / home / work
Alternate Phone #_____ cell / home / work
Email Address: _____

Is Patient:
Diabetic: YES / NO (please circle)
Latex Allergy: YES / NO (please circle)

Diagnosis (if known):_____
Date of Onset (if known):_____

Person Financially Responsible/Guarantor: _____ Relationship to Patient: _____
Date of Birth:_____ Social Security Number: _____ - _____ - _____ Email Address:_____
Cell#:_____ Home#:_____ Work#:_____
Address _____ City_____ State: _____ Zip_____ **(If same address, write SAME AS ABOVE)**

Other Parent's Name: _____ Cell#:_____ Home#:_____ Work#:_____

Person to Notify in Case of Emergency _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance Company _____
ID # _____ Group #/Name _____

Policy Holder's Name _____ Sex M/F ____ Date of Birth _____
Policy Holder's Address _____ SS# _____ - _____ - _____
City _____ State _____ Zip _____ Phone # _____
Relationship of Patient to the Policy Holder: SELF HUSBAND WIFE CHILD PARENT OTHER

Secondary Insurance Company _____
ID # _____ Group #/Name _____

Policy Holder's Name _____ Sex M/F ____ Date of Birth _____
Policy Holder's Address _____ SS# _____ - _____ - _____
City _____ State _____ Zip _____ Phone # _____
Relationship of Patient to the Policy Holder: SELF HUSBAND WIFE CHILD PARENT OTHER
