USA Prosthetics Registration

Date

Patient's Last Name First Middle Date of Birth

☐ Male ☐ Female SS # E-mail Driver's Lic.#

Vocational Category: ☐ Full-Time ☐ Part-Time ☐ Employed ☐ Student ☐ Disability ☐ Unemployed ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

Home Phone Cell Phone Work Phone

Home Address: Street

City State Zip

Employer/School Name Name of Responsible Party

Address Phone

Emergency Contact Relationship to Patient

Address Phone

Referring Physician Phone

Primary Physician Phone

Physical Therapist Phone

Who referred you to USA Prosthetics?

In most instances, we will bill your insurance and co-insurance for payment of our services. However, we do request payment for certain orthotic devices at the time of delivery. We will provide you with the necessary paperwork to file with your insurance company if you wish. Your coverage is a contract between you and your insurance carrier. You are responsible for your entire balance in circumstances where your insurance company denies coverage, as well as any remaining balance after insurance has paid. If this matter is turned over for collection, you will be responsible for all collection fees and attorney/court costs incurred. Your signature below indicates your understanding and agreement to accept responsibility for any and all charges incurred through this office. Thank you.

☐ By checking this box I submit my electronic signature below to serve in place of my authorized, hand-written personal signature.

Electronic Signature of Responsible Person Date

Patient Medical History

Reason for Visit

Diagnosis for Visit

Is your condition a result of an accident: ☐ Work ☐ Auto ☐ Other

Type of Accident

General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Activity Level: ☐ Low ☐ Medium ☐ Active ☐ Highly Active

☐ Height ☐ Weight ☐ Shoe Size

Have you received any orthotics or prosthetics within the last five (5) years? ☐ Yes ☐ No

If yes, please list item and date:

Description of past surgeries:

Date

Date

Date

Date

Please identify current medical conditions:

☐ Heart Problems ☐ Hepatitis A/B ☐ Parkinson Disease ☐ Hypertension ☐ HIV Positive ☐ Alzheimer Disease ☐ Vascular Disease

☐ Rheumatoid Arthritis ☐ Psychiatric Problems ☐ Stroke ☐ Obesity ☐ Alcoholism ☐ Diabetes ☐ Pulmonary Disease

☐ Kidney Problems ☐ Vision Problems

Allergies:

Medication currently taking:

Primary Insurance Information

Is this a Worker's Comp Case? ☐ Yes ☐ No

Primary Insurance Company ______ Group # ______ ID# ______

Address ______

City ______ State ______ Zip ______

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other

Insured's Name ______ Effective Date ______

Insured's Date of Birth ______ Insured's SS# ______ ☐ Check if copy of insurance card has been provided

Secondary Insurance Information

Is this a Worker's Comp Case? ☐ Yes ☐ No

Secondary Insurance Company ______ Group # ______ ID# ______

Address ______

City ______ State ______ Zip ______

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other

Insured's Name ______ Effective Date ______

Insured's Date of Birth ______ Insured's SS# ______ ☐ Check if copy of insurance card has been provided