



ATLANTIC PROSTHETICS AND ORTHOTICS, LLC

Patient's Name _____ Male ___ Female ___
(Last) (First)

Birthdate _____ Social Security _____

Address _____

City _____ State _____ Zipcode _____

Home Phone _____ Cell _____ Work _____

Email Address _____

Parent or Responsible Party(if patient is a child) _____

Address(if different from above) _____

Emergency Contact _____ Phone Number _____

Are you currently living in a Skilled Nursing Facility? ___ Yes ___ No Anticipated discharge date _____

MEDICAL INFORMATION

Weight _____ Height _____

Are you Diabetic? ___ Yes ___ No Doctor treating your Diabetes _____

Date of Amputation _____ Injury Date _____

Referring Physician _____ Phone # _____

Primary Diagnosis _____

Have you had a orthopedic device(shoes,brace, prosthesis) in the last five years? ___ yes ___ No

If yes, how long have had the device _____

INSURANCE INFORMATION

We will verify your insurance for the equipment prescribed by your physician and advise you of your benefit information received. We are not responsible for incorrect benefit information provided by your insurance during this verification process. Please refer to your benefits book and/or consult your insurance carrier for assistance.

Primary Insurance _____ Policy# _____

Group# _____ Policy Holder's name and DOB _____

Secondary Insurance _____ Policy# _____

Group# _____ Policy Holder's name and DOB _____

Tertiary Insurance _____ Policy# _____

Group# _____ Policy Holder's name and DOB _____

I authorize the release of any medical information necessary to process claims and request payment of benefits to Atlantic Prosthetics & Orthotics, LLC. I understand that I am responsible for any remaining balance not covered by my insurance.

Signature: _____ Date: _____