PATIENT REGISTRATION FORM

GENERAL INFORMATION

Patient Last Name	First Name (Legal)	MI	Preferred Name	Date of Birth	Gender ☐ M ☐ F	Social Security Number ___-__-____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Employed ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Disability ☐ Student

Home Street Address	City	State	Zip Code

CONTACT INFORMATION

Preferred Language ☐ English ☐ Other: ______	Cell Phone ( )	Home Phone ( )	Work Phone ( )	Preferred Phone ☐ Cell ☐ Home ☐ Work

Email Address	Permission to Text/Email Appointment Reminders? ☐ Yes ☐ No Information About Treatment? ☐ Yes ☐ No	Preferred Method of Contact ☐ Voice Call ☐ Text ☐ Email

MEDICAL INFORMATION

Height	Weight	Recent Weight Change ☐ Yes ☐ No	List any known allergies related to contact materials (i.e. latex, wool, etc.)

Have you received an orthotic or prosthetic device(s) within the last 5 years? ☐ Yes ☐ No *If yes*, what device(s) have you received and when? ______________________________ Has your condition changed since you received the device? ☐ Yes ☐ No	Name of Referring Physician Group/City
Have you consulted with your physician about your orthotic/prosthetic need? ☐ Yes ☐ No When? ______________________	Name of Primary Care Physician Group/City
Is your condition the result of…? (check all that apply) ☐ Work place accident ☐ Car accident ☐ Condition since birth ☐ Other	Name of Therapist ☐ PT ☐ OT Group/City

PATIENT CONTACTS

Insurance Subscriber Name	Relation to Patient	Subscriber DOB	
Responsible Party / Emergency Contact	Relation to Patient	Phone ( )	Phone Type ☐ Cell ☐ Home ☐ Work

The above information is true to the best of my knowledge. I authorize and assign my Medicare and/or other insurance benefits to be paid directly to Arise O&P. I authorize Arise O&P and its affiliates to release any part of my medical record and related information required to process claims. I understand that Arise O&P will file a claim with my insurance(s) on my behalf, but that I am ultimately financially responsible for the entire bill. I understand that without sufficient verification of current medical insurance coverage, payment is due at time of service/delivery. By signing below, I am also acknowledging acceptance of Arise O&P HIPAA Notice of Privacy Practices and warranty information.

____ ______________________

Patient/Guardian Signature Date