Arise
Orthotics & Prosthetics, Inc.

REGISTRATION FORM – Please Print Legibly

Today's date:	Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Height: Weight:	Birth Date:	Age:	Sex: ❑ M ❑ F

Street address:		Best Phone # to Reach Me: ( )

City:	State/Zip:	Social Security No:	Second Phone: ( )

Occupation:	Employer: Address:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Ad	❑ Other

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist for copying.
If information is same as above, write "SELF" and skip to SIGNATURE.
If subscriber name is different on insurance card, please fill out all information below.

Subscriber's Name (or SELF):	Birth date: / /	Subscriber's Address:	Best phone no.: ( )

Patient's Relationship to Subscriber:	Spouse	Child	Other:

Subscriber SS#:	Employer:	Employer address:	Employer phone no.: ( )

PRIMARY INSURANCE:

Medicare	❑ MN MA or MHCP	❑ BCBS	❑ Health Partners	❑ Medica	❑ Preferred One

❑ Humana	❑ UCare	❑ United Healthcare	Other:	

ID#:	Group#:	Policy#:	Phone:	Address:

SECONDARY INSURANCE:	ID#:	Group#:	Phone:	Address:

Worker's Compensation Carrier:	W/C Contact Name:	W/C Contact Phone:	Date of Injury:

W/C Claim Number:	W/C Address:		

SIGNATURE/IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Best phone: ( )	Second phone: ( )

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 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*