prosthetic
& orthotic
associates

3160 Southgate Commerce Blvd.
Suite 38
Orlando. FL 32806
P. 407-245-7770 F. 407-245-7727

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Alternate Phone: _____

SS#_____DOB:_____ Gender:___M___F Ht:_____Wt:_____Diagnosis/Type of Amputation:_____

Driver's License No. _____ Marital Status _____ E-Mail Address _____

Emergency Contact _____ Medical Concerns _____

Date of Amputation (if applies) _____ Affected Side: _____ Left _____ Right _____ Bilateral _____ N/A

How did you hear about us? _____ Inmotion Ad _____ Website _____ Referral (Referred by _____) _____ Other

Physician Information

Referring Physician Name: _____ UPIN: _____ Medipass #: _____

Street Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Primary Physician Name: _____ UPIN: _____ Medipass #: _____

Street Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____ Relationship to Insured: _____

Street Address: _____ City, State, Zip: _____

Phone: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____ Relationship to Insured: _____

Street Address: _____ City, State, Zip: _____

Phone: _____

Guarantors Name (if patient is a minor):_____ Guarantors SS# _____

If Workman's Comp: Claim Number _____ Date of Accident: _____ Adjuster Name _____ Adjuster Phone: _____

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:
I request my insurance benefits, if any, be paid directly to Prosthetic and Orthotic Associates of Central Florida. I authorize the release of any information necessary to provide services or process claims. I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or not-covered. In the event my insurance carrier does not except Assignment of Benefits or if payments are made directly to me or my representative, I will endorse such payments to POA. I agree to notify Prosthetic and Orthotic Associates immediately of any change in insurance coverage or status.

I understand that I have the right to request and receive a **Notice of Privacy Practices from POA.**

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature: Relationship Date