Able Prosthetic Care, Inc.

PATIENT INFORMATION

Name____ ☐ **Male** ☐ **Female**
(Last) (First) (MI)

Date of Birth ______________________ Social Security #________-_______-__________

Street Address____

City____________________State____________________Zip______________

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone________________________Cell Phone________________________

E-mail address____

Employer_________________________________Business Phone______________

Business Address__________________________Occupation__________________

Emergency contact_________________________Phone #____________________

Medical information

Height ______________ Weight _________(lbs.) Diabetic ☐Yes ☐No

Date of Amputation _________________ Injury Date if different ______________

Type or level of amputation ____

Cause of Amputation ____

Referring Physician_______________________________Phone_______________

Primary Insurance

Primary Insurance________________________________Phone #_______________

Address____

Group #_____________________________Subscriber ID #__________________

Subscriber's Name___________________________Relation to Patient_____________

Birth date ______________________________Social Security #________________

Secondary Insurance

Secondary Insurance______________________________Phone #_______________

Address____

Group #_____________________________Subscriber ID #__________________

Subscriber's Name___________________________Relation to Patient_____________

Birth date ______________________________Social Security #________________

By signing below I authorize Able Prosthetic Care, Inc. to carry out the instructions on prescriptions from my physician. I further authorize Able Prosthetic Care, Inc. to acquire and file any forms, documents or information necessary for billing purposes. This includes obtaining copies of my medical records from the referring physician. I also authorize Able Prosthetic Care, Inc. to make and use any photographs or video deemed necessary to support my claim and to document my condition. This is also authorization for payment to be made directly to Able Prosthetic Care, Inc. I understand that I am responsible for any deductible or co-payment that my insurance does not cover and that if my insurance does not pay for services rendered, I will be responsible for payment in full.

Signed____ Date_______________________