# Welcome!
# Snell's Limbs and Braces

## Patient Information Form

**Please PRINT LEGIBLY and make sure you complete all information on form.**

**Section I** **Patient Information** **Date_____**

Full Name:_____ I Prefer to be called:_____

Date of Birth:_____ SS#:_____Gender: ☐ F ☐ M

Driver License #:_____Email_____

Vocation: ☐ Employed ☐ Retired ☐ Student ☐ Disabled ☐ Unemployed ☐ Unspecified

Employer_____ Work Phone(_____)_____

Home Phone (_____)_____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M.

Address:_____City:_____State:_____Zip_____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Person to contact in case of emergency_____

Relationship to Patient_____ Phone_____

Referring Physician _____ Primary Physician_____

**Section II** **Responsible Party**

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ VA ☐ Other

Name:_____

Address:_____City:_____State:_____Zip_____

Phone: (____)_____Date of Birth_____SSN#_____

Email_____

Employer_____ Work Phone(_____)_____

**Section III** **Insurance Information** **(if applicable)**

Name of Insured_____Relationship to Patient _____

Date of Birth_____Social Security #_____

Name of Employer:_____ Work Phone: (____)_____

Insurance Company_____

ID#_____ Grp #_____ Plan #_____

**** DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:*

Name of Insured_____Relationship to Patient _____

Date of Birth_____Social Security #_____

Name of Employer:_____ Work Phone: (____)_____

Insurance Company_____

*****PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE/PHOTO ID.*****

**Section IV** **Medicare Services** **(if applicable)**

Are you enrolled in a Medicare HMO/Managed Care Program? ☐ Yes ☐ No

Have you received the same or similar equipment before? ☐ Yes ☐ No

If yes, please describe the service & when_____

**Section V** **Worker's Compensation** **(if applicable)**

Were you injured on the job? ☐ Yes ☐ No Date of Accident_____

Your Employer_____Employer's Phone #_____

Claim #_____Claim Adjuster_____ Phone #_____

## Insurance Authorization and Medical Release of Information

I authorize that payment of medical benefits (Medicare, Medicaid, Worker's Compensation, private insurance, or other) be made either to me or Snell's Limbs & Braces for any O&P services necessary per my physician's prescription. I understand that I may be financially responsible for any amount not covered. I also authorize the release of any medical or other information necessary to process this claim.

**Patient Signature_____Date_____**