PATIENT INFORMATION

We are able to serve you better in filing of your insurance and medical care if all information is provided below.

Patient Name:					_	☐ Female
	First	Middle		Last		
Address:	Street			City	State	Zip Code
Date of Birth:	SSN:		Height	Weight	Marital S	tatus
Telephone:	V	Vork:		Cell:		
Email Address:						
Emergency Contact: Name:_	Contact: Name:		Phone	Relationship		
Additional Contact: Name:		Phone	hone Rela		itionship	
Referring Physician:	ian:		one:	City:		
Primary Physician:	:		one:		City:	
Are you currently: Employ Employer's Name (Provide parent's employer information if patie	ent is a child.)		F	Phone:		
Is patient a diabetic? Yes Is this a work related injury Adjuster's Name	y? 🗌 Yes 🔲 No	Date of Injury		Claim #_		
Primary Insurance:		Policy Number	:	Phone	Number:	
Insured's Name:		Date of	Birth		_ Phone:	
Secondary Insurance:		Policy Number: _		Phone	Phone Number:	
Insured's Name:		Date of	Birth		_ Phone:	
Signature of patient or guarar	ntor				Date	



Tel: (901) 757-5461 Fax: (901) 757-0909

HIPAA Documents and Supplier Standards Receipt

I,, and I agree to the (Date)	, have received the following document(s) on terms listed within them.		
Document Name	Description		
Assignment of Benefits authorization to release information.	Assignment of Benefits & Authorization		
Copy of Warranty & Payment Agreement Policy	Warranty Policy		
MEDICARE DMEPOS SUPPLIER STANDARDS	Supplier standards that our facility must conform to provide O & P care.		
Privacy Practice.	Acknowledgement Receipt of Notice of Privacy Practices.		
Patient (or quardian)	Data		
Patient (or guardian)	Date		

NOTICE OF CONFIDENTIALITY: This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.