Patient Account No: _____

Action Orthopedic Co. LLC– Patient Information Sheet

Patient Information

Since your last visit at our office, has any of your information changed? Yes / No If yes please update the information below.

Name: Weight: Height:

DOB: Age: Sex: Marital Status:

Address:

Tel:

Alt Tel: Alt Tel Type: Email:

Soc Sec#: Drivers Lic:

Employer: Employer Tel:

Employer Address:

Spouse or Parent Name: Tel:

Friend or Relative not living with you: Tel:

Primary Physician: Tel:

Referring Physician: Tel:

Service Information

What is the reason for your visit (Prosthetic, Orthotic, or Mastectomy)? _____

Have you ever received the same or similar device? Yes / No
If yes, list the device: _____
Where was the device provided? _____
Date Provided: _____
(Please circle one) Device needs to be: Repaired / Replaced?

New Patients Only
How did you hear about us?
- ☐ Physician
- ☐ Online
- ☐ Friend
- ☐ Other:_____

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Action Orthopedic Company for any services provided to me by Action Orthopedic. I hereby assign, transfer, and set over all of my rights, title, and interest of my medical reimbursement benefits under my insurance policy for services provided to me by Action Orthopedic Company. I authorize any holder of medical information about me to be released to determine the benefits. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I have read the financial policy presented to me and posed in the waiting room and agree to this financial policy.

The "Notice of Privacy Practices" is available in the office for my viewing. With my Consent, Action Orthopedic Company may use and disclose Protected Health Information (PHI) in order to carry out treatment, payment and health care operation. With my consent Action Orthopedic Company may also call my home and leave a message; send reminders/requests for appointment by mail; speak to other members of my household by telephone.

***Medicare Patients Only: I have received a copy of the Medicare Supplier Standards.**

_____ _____
Signature of Patient or responsible party Date