Sawtooth Orthotics & Prosthetics, Inc.

Patient Account #

PATIENT INFORMATION

Name:

Address:

City:

State: Zip:

Home Phone

Work Phone:

Cell Phone:

Date of Birth:

☐ Male ☐ Female

SS#:

Email Address:

Referring Dr:

Primary Physician:

PARENT / LEGAL GUARDIAN

Name:

Address:

City:

State: Zip:

Phone #:

PAYMENT RESPONSIBILITY

Complete if different from above

Name:

Address:

City:

State: Zip:

Phone #:

DOB: SS#:

Relationship to Patient:

*****LATEX ALLERGY? ☐YES ☐NO**

I authorize Sawtooth Orthotics & Prosthetics to release any clinical or financial information in person or over the phone to:

Name: _____

Relationship: _____

Signature: _____

INSURANCE INFORMATION

Company:

ID#: Grp#:

Policy Holder:

DOB: SS#:

Relationship to Patient:

SECONDARY INSURANCE

Company:

ID#: Grp#:

Policy Holder:

Date of Birth: SS #:

Relationship to Patient:

WORKMAN'S COMPENSATION

Date of Accident:

Insurance Company:

Claim #:

Contact:

PLEASE READ – SIGN – DATE

If patient is unable to sign, please indicate

Reason:

Signers Authority/Relationship:

Sawtooth Orthotics & Prosthetics, Inc. agrees to bill most insurance carriers, if all necessary information is provided.

I, the patient or legal representative, agree to be financially responsible for all charges whether or not paid for by insurance.

I assign to Sawtooth Orthotics & Prosthetics, Inc. permission to bill my insurance company and release information pertaining to claim submittal.

I acknowledge receipt of the main patient intake brochure which includes:

SIGNATURE: _____

DATE SIGNED: _____