BOLAND PROSTHETIC & ORTHOTIC CENTER

New Patient Registration Form

Patient's Full Name _____

Social Security Number _____ D.O.B _____/_____/_____

Home Phone # _____-_____-_____ Mobile Phone # _____-_____-_____

Sex: M ☐ F ☐ Height:_____ Weight: _____ Drivers License #: _____

Home Address _____

City _____ State _____ Zip _____

Email Address: _____

Marital Status (circle one) Single Married Widowed Divorced

Language spoken (circle one) English French Spanish Other

Are you currently in a nursing home / assisted living home? YES NO

If yes, name of facility _____ Date of Admin: ____-____-_____

Address: _____ Phone #: _____

☐ I give Boland Prosthetic & Orthotic Center permission to call/text/email me and leave medical information pertaining to my care at the listed methods and accept responsibility to notify the office of any change to this information.

Employment Status

☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Student ☐ Other

If employed, name of employer: _____

Responsible Party Information

If the responsible party is anyone other than the patient please indicate this below

Name _____Phone # _____-_____-_____

Address _____ City _____ State _____ Zip _____

Emergency Contact

Name: _____Relationship: _____

Phone: HOME # _____-_____-_____ CELL # _____-_____-_____

Address (if different than patient): _____

_____

☐ I authorize Boland Prosthetic & Orthotic Center to release medical information to the above mentioned contact.

Release of Health Information

I, _____, hereby authorize Boland Prosthetic & Orthotic to use or disclose the following information, during the patients period of care, from the health records of:

Patient Name: _____D.O.B _____/_____/_____
This Authorization Shall end on (cancelation of access to records) : ____/____/_____

The information to be disclosed (Please Check One or more):

☐ Complete Health Record ☐ Consultation Report
☐ Inpatient Records
☐ History & Physical Examination/Progress Reports

This information is to be disclosed for the purpose of INSURANCE BENEFITS/INSURANCE AUTHORIZATION and is to be sent to BOLAND PROSTHETIC & ORTHOTIC CENTER.
I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance upon this authorization. The facility, its employees, and practitioners are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ ____/____/____
Signature of Patient or Legal Guardian Date

Medical Conditions (Check All That Apply)

__Alzheimer's or dementia
__Anxiety
__Asthma
__Brain Injury/TBI
__Cancer
__Depression
__Diabetes Type I
__Diabetes Type II
__Hearing Loss
__Heart Problems
__Hepatitis
__High Blood Pressure
__HIV
__Infections
__Intestinal Problems
__Kidney Disease
__Liver Disease
__Migraines
__MRSA
__Neurological Problems
__Obesity
__Osteoarthritis
__Osteoporosis
__Parkinson's Disease
__Pulmonary Disease (TB
__Rheumatoid Arthritis
__Seizures
__Skin Problems
__Stomach Problems
__Stroke/TIA/CVA
__Vascular Disease
__Vision Problems

I acknowledge all the above information, in its entirety, is correct and I accept financial responsibility for any services offered for my dependent or myself

Signature_____Date____/____/_____

** INSURANCE INFORMATION **

Primary Insurance Information

Name of Primary Insurance _____

Primary Insurance Address _____

City _____ **State** _____ **Zip** _____

Insurance Phone Number _____-_____-_____

Policy Number _____ **Group #** _____

Is the patient the subscriber for the Primary Insurance? Yes _____ No _____
(If no, please complete the section below.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
D.O.B _____/_____/_____ **Sex:** M ____ F ____
Subscriber SS# _____-_____-_____ **Subscriber main phone #** _____-_____-_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____-_____-_____

Secondary Insurance Information (if applicable)

Name of Secondary Insurance _____

Secondary Insurance Address _____

City _____ **State** _____ **Zip** _____

Insurance Phone Number _____-_____-_____
Policy Number _____ **Group #** _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
D.O.B _____/_____/_____ **Sex:** M ____ F ____
Subscriber SS# _____-_____-_____ **Subscriber main phone #** _____-_____-_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____-_____-_____

Tertiary Insurance Information (if applicable)

Name of Tertiary Insurance _____

Tertiary Insurance Address _____

City _____ **State** _____ **Zip** _____

Insurance Phone Number _____-_____-_____

Policy Number _____ **Group #** _____

Is the patient the subscriber for the Primary Insurance? Yes _____ No _____
(If no, please complete the section below.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
D.O.B _____/_____/_____ **Sex:** M ____ F ____
Subscriber SS# _____-_____-_____ **Subscriber main phone #** _____-_____-_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____-_____-_____