FLOYD BRACE
ORTHOTICS AND PROSTHETICS

Patient Information 2017

Patient Name _____ **Date of Birth** _____ /_____ /_____

Sex _____ **Ht:** _____ **Wt:** _____ **Social Security #:** _____

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

Phone #'s Home _____ **Work** _____ **Cell** _____

Email _____

***Referring Physician** _____ ***Primary Physician** _____

Diagnosis _____ **Date of Injury/Surgery** _____

Other Conditions/ Allergies _____

***Responsible Party – if different from patient or if patient is 17 years old or younger this information is required for all insurance plans**

Name _____ **Relationship** _____

Address _____ **City** _____ **State** ___ **Zip** _____ **Phone#** _____

If Insured, Please Complete: Social Security # _____ ***DOB**: _____ / _____ / _____

Insurance Information

Primary Insurance _____ **Secondary Insurance** _____

Tertiary Insurance _____

Was this an accident? (circle one) Yes / No **Is this covered by Workman's Comp. Insurance? Yes / No**

Additional Contact Information

Name _____ **Relationship** _____

Address _____ **Phone #** _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY, BENEFITS AND MEDICAL INFORMATION RELEASE

I authorize all providers, care givers, and payers to release any information necessary to provide services or process claims. I specifically request that any benefits due from my insurers be paid directly to Floyd Brace company, Inc. or its assigns. I understand that I am responsible for any balance not paid or covered by my insurance company (s). I understand that prior authorization or pre-approval by my insurance company is not a guarantee of payment. I agree to pay any and all amounts remaining due for the services rendered at Floyd Brace company, Inc. and its assigns. I have received / read a copy of the Floyd Brace Company, Inc. Notice of Privacy Practices. The above information is true and correct to the best of my knowledge and I will provide updated information if it should change.

I agree to the above terms and conditions:

Signature: _____ **Date:** _____