Lubbock Artificial Limb & Brace, Ltd.

PATIENT REGISTRATION

SECTION 1: PATIENT INFORMATION	
Personal Information	Mr/Ms/Mrs First:_____MI: _Last:_____ Address:_____City_____State Zip Code_____ Home Phone: ( )_____Work Phone: ( )_____ Cell: (____)_____ Emergency Contact Phone: (____)_____ Email Address: _____ Social Security Number: _____ Male / Female: __ M __ F Marital Status:_____ DOB:_____ Guarantor:_____Patient Relationship to Guarantor: __Self __Spouse __Child __Other Guarantor Address:_____City:_____State:____Zip Code:_____ Phone ( )_____ Power of Attorney: __ Yes __No Occupation:_____ Employer:_____ Employer Address_____ Employer Phone: ( )_____
Physician Information	Referring Physician: _____Phone: (_____)_____ Primary Care Physician:_____Phone: (_____)_____
Condition Information	Are you a diabetic? __ Yes __ No If yes, name and address of physician treating your diabetes: Physician Name:_____Phone: (_____)_____ Address: _____ Have you received a similar service in the past five years? __ Yes __ No Where?_____ Are you in hospice care? __ Yes __ No Are you a resident of a skilled nursing (nursing home) facility? __ Yes __No
Amputation Information	Date of Amputation_____ Cause of Amputation_____ Level of Amputation: _____ Left_____ Right_____
Is Your Condition the Result of Any Injury?	__ Yes __ No If no, please skip to Insurance Information below.
Was Injury Work Related?	__Yes __ No If yes, name of employer at time of accident:_____ Employer Name:_____ Address:_____City_____State_____Zip Code_____ Contact Person:_____Phone: (____)_____Claim #:_____
Was Injury Result of an Automobile Accident?	__Yes __No If yes, name of adjuster:_____ Name:_____Phone: (____)_____Claim #:_____ Current Employer:_____

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SECTION 2: INSURANCE INFORMATION	
Primary Insurance	Primary Insurance:_____ Address/Phone:_____ Policy #:_____ Group #:_____ Name of Insured:_____ Relationship:_____ DOB: _____
Secondary Insurance	Secondary Insurance:_____ Address/Phone:_____ Policy #:_____ Group #:_____ Name of Insured:_____ Relationship:_____ DOB: _____

Please present the receptionist with your insurance card(s) so we may make copies.

I certify that the information provided by me is true, accurate and complete.

_____ _____

Signature of Patient / Guarantor Date