



PATIENT INFORMATION

Patient Name, Date of Birth, Social Security#, Drivers License#, Address, City, State, Zip, Phone#, Secondary/Cell Phone#, Marital Status, Gender, Height, Weight, Employer, Employer's Phone#, Address, City, State, Zip

REQUIRED for insurance billing purposes:

Referring Physician's Name, Phone #, Diagnosis/Nature of injury, Date of Injury, Affected Side (Right, Left, N/A)

(If patient is a minor) Responsible Party Name

Address, City, State, Zip, Phone#, Secondary Phone#

Insurance Information

Is this a Worker's Comp case? Yes No

Primary Insurance, Address, City, State, Zip, Phone#, Policy#, Group#, Name of Insured, Date of Birth, Relation (Self, Spouse, Parent/Guardian), Secondary Insurance (if necessary)

Medicare Patients, please answer the following:

Has the patient ever received the same or similar supplies/equipment? Yes No. If so, list equipment/supplies: Who was it purchased or rented from? Date purchased or rented: Date of past set-up: Date equipment was returned: Was item returned to original supplier? Yes No. Why was the item returned? Is the item being replaced? Yes No. Is there a new medical necessity? Yes No. Describe condition for previous need: Describe new/changed condition:

Assignment of Benefits/Authority for Release of Information

I request that payment of authorized Medicare, Medical, Private Insurance or Worker's Compensation be made to Stellar Prosthetics and Orthotics Inc. for any covered services furnished to me by Stellar Prosthetics and Orthotics Inc. I authorize any holder of medical information about me to release, to the Health Care Financing Administration and its agents, Champus and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for charges in a timely manner, or my physician or I fail to provide within (30) days the information necessary to submit the claim for payment.

X BENEFICIARY/PARENT/GUARDIAN/REPRESENTATIVE DATE

\*PLEASE ALSO SIGN THE FOLLOWING PAGES. THANK YOU\*