ELITE ORTHOTICS

NEW PATIENT INFORMATION

Patient name:_____Date of birth:_____

Age:_____Social security #:_____Sex: Male:_____ Female:_____

Home phone:_____Cell phone:_____Work phone:_____

Mailing address:_____City:_____State:_____Zip:_____

Physical address (if different from above):_____

Employer:_____City:_____State:_____Zip:_____

RESPONSIBLE PARTY INFORMATION (INSURANCE POLICY HOLDER)

Name:_____Social security#:_____Date of birth:_____

Address:_____City:_____State:_____Zip:_____

Relationship to patient:_____Driver's license#:_____

Home/Cell phone:_____Work phone:_____

INSURANCE INFORMATION

Primary:_____Secondary:_____

Is this visit due to the result of a car accident? Yes:_____ No:_____

Are you seeing an attorney due to this injury: Yes:_____ No:_____

Is this a Workman's Comp. Injury? Yes:_____ No:_____ Date of Injury:_____

Workman's Comp. Insurance carrier:_____Claim#:_____

Address:_____City:_____State:_____Zip:_____

Adjuster's name:_____Phone:_____Email_____

*Emergency contact: Name:_____Phone:_____

Relationship:_____Address:_____

*Ordering Physician's Name:_____

PATIENT INFORMATION

Height _____ *Weight*_____ *Shoe Size*_____

PLEASE NOTE, PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

I authorize the release of any information required to process this claim. I authorize payment of medical benefits to ELITE ORTHOTICS', for any medical services provided. I understand that I am financially responsible for all services provided (including non covered services of Medicare and/or Medicaid).

Signature:_____Date:_____

532 N. TELSHOR BLVD. STE. H LAS CRUCES, NM 88011
Phone: 575.210.1495 | Fax: 575.221.9055
ELITEPRIMARYNM.COM

Notice of Privacy Practices

I certify that I have been informed of Elite Orthotics' Notice of Privacy Practices. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Elite Orthotics' health care operations. The notice also describes my right and Elite Orthotics' duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front waiting room.

Elite Orthotics' reserves the right to change the Privacy Practices that are describe in the notice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy to be sent in the mail or asking for one at the time of my appointment.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

_____
Witness