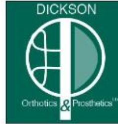

Date________________

Registration/ Insurance Information

PATIENT DEMOGRAPHICS

Patient (Legal) Name First ___________________Middle Initial____________________Last_______________

Social Security # _______-_________-_________**Date of Birth** ______/______/________ **Male** ____ **Female**____

Single____ **Married**____ **Other**_____ **Employed**____ **Retired**____ **Other**_____

Street Address____ **City**_________________ **State**_____ **Zip**_______

Phone_______________________ **Work**__________________ **Cell**________________________________

☐ **By checking this box**, you authorize Dickson Orthotics & Prosthetics to leave detailed messages for you, which may include private healthcare information.

Email___________________________________@_______________________________________

☐ **By checking this box**, you authorize Dickson Orthotics & Prosthetics to utilize email as a form of communication with you. Our communications include information regarding your treatment plan, updates and our services. Your social security number **will never** be included in an email communicate from us.

Emergency Contact: Name_______________________ _______________Phone____________________________

INSURANCE INFORMATION

Primary Insurance ___________________**Policy ID**____________________________**Group**___________________

Secondary Insurance ___________________ **Policy ID**____________________________**Group**_________________

Responsible Party

If the responsible party is someone other than the patient:

Relationship: Spouse____ **Dependent**_____

Legal Name First ______________________Middle Initial____________________Last_______________

Social Security # _______-_________-_________**Date of Birth** ______/______/________

I give permission to Dickson Orthotics & Prosthetics to release my information verbally or written on my behalf to the following persons (Please note that in order for us to communicate with anyone other than the patient/guardian, that individual's name must be listed below).

Name_______________________ Phone____________________ Relationship to Patient____________________

Name_______________________ Phone____________________ Relationship to Patient____________________

I verify that, to the best of my knowledge, the information I have provided is accurate.

Patient/Guardian Signature____ Date _________________