



Arizona Prosthetic Orthotic Services Patient Registration Form

Patient Name: _____ Date of Birth: _____

SSN: _____ Sex: _____ Marital Status: Single Married Other: _____

Home Phone: (____) _____ Alternative Number: (____) _____

Primary Address	Alternative Address
Address: _____ _____	Address: _____ _____
City: _____	City: _____
State & Zip: _____	State & Zip: _____

Height: _____ Weight: _____ Shoe Size: _____

Are you a diabetic? YES NO ****If so, who is your treating physician:** _____

Referring Doctor: _____ **This information is needed to process your claim***

Employer: _____ Occupation: _____

Address: _____

City, State, Zip: _____ Phone: _____

*****This information must be given and fully completed in order for APOS to process your claim*****

Is this a work related injury?: YES NO *If so, please provide the following worker comp info:*

Company Name: _____

Claim Number: _____ Date of injury: _____

Adjuster: _____ Phone: _____

Primary Insurance: _____ Phone #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relation: _____ ID# _____ Group# _____

Secondary Insurance: _____ Phone #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relation: _____ ID# _____ Group# _____

How did you hear about our office?

Dr. _____ Insurance Directory _____ Yellow Pages _____ Friend: _____ Other: _____

The information provided above is full and accurate to my knowledge. If my insurance company fails to pay for services rendered within 90 days, I agree to be responsible for all charges of services rendered. I further release any medical information to process this claim and authorize payment of benefits to the provider for services rendered. I may also be charged any additional fees that may be added to my account if my account is turned over to a collection agency for failure to pay. Also if I am unable to give 24 hours notice for cancellation of an appointment I may be charged a service fee of \$20 dollars. I agree to pay all fees, if any, in the case of a cancelled or returned check submitted by myself to APOS. I have reviewed this information and verify that it is correct. I know that I am responsible for any financial loss, due to inaccurate information provided by me.

Patient Signature: _____ Date: _____