HITTENBERGER
orthotics and prosthetics LLC

Patient Information Form

PATIENT NAME	DOB / /	AGE	MARITAL STATUS ☐S ☐M ☐D ☐W	GENDER ☐M ☐F	SOC. SECURITY NO. / /

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE ( )	MOBILE PHONE ( )	EMAIL ADDRESS

IF A MINOR	MOTHER/FATHER/GUARDIAN'S NAME	SOC. SECURITY NO. / /	DOB / /	PRIMARY PHONE ( )	SECONDARY PHONE ( )
EMERGENCY CONTACT	NAME	RELATIONSHIP		PRIMARY PHONE ( )	SECONDARY PHONE ( )

REFERRAL	REFERRING PHYSICIAN	PRIMARY PHYSICIAN	HEIGHT	WEIGHT
	PHONE ( )	PHONE ( )	SHOE SIZE	AUTO ACCIDENT ☐Y ☐N
	HOW DID YOU HEAR ABOUT US? ☐ SEARCH ENGINE ☐ FACEBOOK ☐ YELP ☐ NEWSPAPER ☐ FRIEND/FAMILY ☐ REFERRING PROVIDER ☐ OTHER ____________________			

EMPLOYER NAME	OCCUPATION	EMPLOYER PHONE ( )

PRIMARY INSURANCE	SECONDARY INSURANCE

INDUSTRIAL INJURY INFORMATION

INDUSTRIAL INJURY	DATE OF INJURY / /	ADJUSTER
INDUSTRIAL INSURANCE CARRIER		PHONE ( )

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all my medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to Hittenberger Orthotics & Prosthetics LLC and agree to notify Hittenberger Orthotics & Prosthetics LLC of any change in insurance coverage or status.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED
DATE