HORIZON PROSTHETICS LLC

Impacting Lives Through Quality Patient Care

Privacy restrictions or other patient requests:

Demographic Sheet

PATIENT INFORMATION

LAST NAME: FIRST NAME: M:

SEX: DATE OF BIRTH: SSN#:

ADDRESS: APT: CITY: STATE: ZIP:

EMAIL: MARITAL STATUS: (Circle one) Single Married Widowed Divorced

HOME PHONE: CELL PHONE: WORK PHONE:

*****Please circle the telephone number where we can best reach you or leave a message*****

SPOUSE/RESPONSIBLE PARTY – INFORMATION

LAST NAME: FIRST NAME: M:

RELATIONSHIP:

EMERGENCY CONTACT: MAIN PHONE:

REFERRING PHYSICIAN: FAMILY PHYSICIAN:

PHONE: PHONE:

ASSIGNMENT AND RELEASE: I hereby certify that the above information is true and correct to the best of my knowledge. I hereby assign my insurance benefits to be paid directly to Horizon Prosthetics. I am financially responsible for **ALL NON-COVERED** services. I also authorize that physician to release any information required to process my claim to insurance company.

X

(Signature of patient or parent/guardian if minor) (Date)

I give permission for my medical information or test results to be released to the following people:

1. Relationship:
2. Relationship:
3. Relationship:

Can we leave a message on your answering machine? (Circle one) YES NO