Orthotics at Home, Inc
6001 Nighthawk Rd
North Little Rock, AR 72118-1733

voice **501-803-3555**
fax **501-803-9555**
e-mail **pkm.oah@att.net**

January 2025

PATIENT INFORMATION FORM

PLEASE FILL THIS FORM OUT COMPLETELY

PATIENTS NAME_____ TODAY'S DATE _____

PATIENT'S BIRTH DATE _____SSN_____FEMALE___MALE___

PARENT / GUARDIAN NAME_____

PATIENT'S BILLING ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE (AREA CODE) _____WORK PHONE_____

CELL PHONE _____

EMERGENCY CONTACT_____PHONE_____

Primary Care Physician _____

Other Insurance Information as applicable (use back as needed)

Please provide copy of all Insurance Cards if applicable

ARKANSAS MEDICAID - ID NUMBER_____

INSURED'S (Policy Holder) FIRST & LAST NAME _____

INSURED'S DATE OF BIRTH (Policy Holder) _____

INSURANCE COMPANY _____

PHONE (AREA CODE) _____

ID#_____POLICY # _____

MEMBER # _____GROUP # _____

CLAIMS ADDRESS_____ PHONE (AREA CODE) _____

CITY_____STATE_____ZIP_____

EMPLOYER (Parent) _____WORK PHONE_____

I authorize medical benefits to be paid directly to Orthotics at Home, INC. I also authorize the release of medical information required to process this claim. I understand that I am responsible for the bill for services provided by Orthotics at Home, Inc. and I Opt-in to receive text messages regarding my care.

ASSIGNMENT AND RELEASE

Signature _____**Date**_____