Atlas
PROSTHETICS & ORTHOTICS

4110 NORTH ST
NACOGDOCHES, TX 75965
Phone: (936) 559-1881
Fax: (936) 559-1890
www.atlaspo.com

Patient Registration

Please complete all sections

Name (First, MI, Last)_____ Date of Birth _____ Age:_____ Sex:_____

Mailing Address (street) _____ Apt #_____

City _____ State _____ Zip_____

SS #_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Phone _____ ☐ Cell ☐ Home ☐ Work Text OK? ☐ Y ☐ N

Secondary Phone_____ ☐ Cell ☐ Home ☐ Work Text OK? ☐ Y ☐ N

Email Address _____

Employer _____ Phone Number _____

Employer Address_____ City _____ State _____ Zip_____

Parent, Spouse, or Responsible Party

(Statements will be addressed to responsible party)

Name (First, MI, Last)_____ Date of Birth _____ Age:_____ Sex:_____

Mailing Address (street) _____ Apt #_____

City _____ State _____ Zip_____

Home Phone _____ Daytime Phone _____ SS #_____

Employer _____ Phone Number _____

Employer Address_____ City _____ State _____ Zip_____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other _____

Insurance Information

Name of Policy Holder (Insured) _____

Date of Birth _____ Policy Holder's Social Security # _____

Insurance Company Name _____ Insurance Phone # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Policy # _____ Group Number_____

Emergency Contact

(Please list someone who does not live with you)

Name_____ Relationship to patient_____ Phone # _____

Address _____ City _____ State _____ Zip _____

Referring Doctor Information

Name_____ Phone # _____

Address _____ City _____ State _____ Zip _____

Fax # _____

Diabetic Doctor Information

Name_____ Phone # _____

Address _____ City _____ State _____ Zip _____

Fax # _____

I have received the Payment Policy and Release of Information. I understand and agree to all its provisions.

X_____

PATIENT / GUARDIAN SIGNATURE DATE

Please send completed form to: info@atlaspo.com or fax to (936) 559-1890