Atlas
PROSTHETICS & ORTHOTICS

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Phone: (281) 781-2751
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Patient Registration

Please complete all sections

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

Mailing Address (street) _____ Apt #_____

City _____ State _____ Zip_____

Primary Phone _____ Secondary Phone_____ SS #_____

Email Address _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Phone Number _____

Employer Address_____

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_____

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

Insurance Information

Name of Policy Holder (Insured) _____ Date of Birth _____

Insurance Comp. Name _____ Insurance Phone # _____

Policy Holder's Social Security # _____

Policy # _____ Group Number_____

In case of emergency (Please list someone who does not live with you)

Name_____ Relationship to patient _____

Address _____Phone # _____

Referring Doctor Information

Name_____ Phone # _____

Address _____ Fax # _____

Diabetic Doctor Information

Name_____ Phone # _____

Address _____ 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 information to: info@atlaspo.com or fax to (281) 602-3451