LA TORRE ORTHOPEDIC LABORATORY
PROSTHETICS & ORTHOTICS

PATIENT REGISTRATION

PATIENT INFORMATION

First: _____ MI:_____ Last: _____ DOB:_____

Sex: ◯ Male ◯ Female ◯ Non-Binary SSN (last four): _____ Marital Status: _____ Employment Status: _____

Address: _____ City:_____ State: _____ ZIP:_____

Cell/Mobile Phone: _____ Secondary Phone:_____ ◯ Cell ◯ Home ◯ Work

Email: _____ Are you a veteran: ◯ Yes ◯ No If yes, are you registered with VA? ◯ Yes ◯ No

CONTACTS

Emergency Contact: _____ Relation to Patient: _____ Contact Phone: _____

Is patient also the guarantor? ◯ **Yes** ◯ **No** If yes, skip to PHYSICIAN INFORMATION.

Guarantor Name: _____ Guarantor DOB: _____ Relation to Patient: _____

Guarantor Phone: _____ Address: _____ City:_____ State:___ ZIP:_____

PHYSICIAN INFORMATION

Referring Physician: _____ Group/Organization: _____ Phone: _____

Primary Care Physician: _____ Group/Organization: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber Name (if different than patient): _____ DOB of Subscriber: _____ Phone: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber Name (if different than patient): _____ DOB of Subscriber: _____ Phone: _____

WORKER'S COMPENSATION INFORMATION / NO FAULT INFORMATION (IF APPLICABLE)

Insurance Carrier: _____ Employer: _____

Address: _____ City: _____ State: ____ ZIP: _____

Date of Injury: _____ Case/Claim #: _____ Adjuster: _____ Phone Number:_____

CONDITION & HEALTH INFORMATION

Height: ____ft _____inches Weight: _____lbs Shoe Size: _____

Are you diabetic? ◯Yes ◯ No If yes, Physician Name: _____ Phone: _____

Have you received a similar service in the past 5 years? ◯Yes ◯No If yes, where: _____

Are you currently participating in Physical Therapy? ◯Yes ◯No If yes, where: _____

How were you referred to La Torre? Physician: _____ Therapist: _____ Existing Patient: _____ Other: _____

I certify that the information provided by me is true, accurate and complete.

Signature of Patient/Guarantor: _____ **Date:** _____

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PATIENT REGISTRATION SIGNATURE PAGE

Patient Name (print): _____ Date: _____

Do you authorize La Torre to contact you via TEXT MESSAGE? ◯ Yes ◯ No

Do you authorize La Torre to contact you via EMAIL? ◯ Yes ◯ No

Revocation of authorization to contact me via email and/or text: I understand that I may revoke my consent for future communications via email and/or text at any time by advising La Torre Orthopedic Laboratory in writing. My revocation of authorization will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Text Communication Disclaimer: I understand that text message and data rate charges from my mobile phone provider may apply. Please be advised that text communication is not always secure. I will inform La Torre Orthopedic Laboratory should my mobile number change.

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility and Receipt of Notice of Privacy Practices

I request my insurance benefits, if any, be paid directly to La Torre Orthopedic Laboratory. I authorize the release of any information necessary to provide services or process claims. I have read and understand the above and permit a copy of this authorization to be used in place of the original. My signature below also indicates that if I am a Medicare patient, I have received or been given the opportunity to receive a copy of the Medicare Supplier Standards. As the responsible party I understand that I am personally responsible for the entire amount of any services furnished and that insurance benefits may be limited or non-existent. I agree to notify La Torre Orthopedic Laboratory immediately of any change in insurance coverage or status.
In addition, you acknowledge that you have received or been given the opportunity to receive a copy of La Torre Orthopedic Laboratory's Notice of Privacy Practices.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party: _____ Relationship to Patient: _____