Rocco Prosthetic and Orthotic Center

PLEASE PRINT

Patient Name: _____ Home Phone: _____
Last First Middle

Street Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SS#: _____

Height: _____ Weight: _____ Age: _____ Sex: _____

Marital Status (Circle One): **S M D W** Emergency Contact: _____ Phone #: _____

Referring Physician & Phone Number: _____

Primary Care Physician & Phone Number: _____

Have you ever been diagnosed with MRSA, HIV, or any other viral infection? _____

Main Diagnosis: _____

Are you a diabetic? (Circle One): Yes or No If yes, who is your doctor treating your diabetes? _____

Please list any non-drug allergies (latex, adhesives, chemicals, etc.): _____

Please list any Medications: _____

Patient's Relationship to Insured/Responsible Party (Circle One): Self Spouse Child Other: _____

Was injury due to an Auto or Work accident? (Circle one): Auto Work Neither

Primary Insurance: _____ ID#: _____

Address: _____

Name of Insured: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ ID#: _____

Address: _____

Name of Insured: _____ DOB: _____ Relationship: _____

BWC Insurance: _____ Claim #: _____ Date of Injury: _____

Employer Name & Address: _____

Contact Person: _____ Phone #: _____

I hereby authorize 'Rocco Prosthetic & Center, Inc.' to evaluate, treat and furnish services of all aspects of my infirmity. I also consent to RPOC supplying any necessary information to insurance carriers and state agencies concerning my (or my dependent's) illness, treatments, and services rendered. I request and authorize payment directly to RPOC from any carrier or agency, less any co-payments, deductibles or non-covered services, which I am responsible for paying. RPOC will not be responsible for any equipment or supplies left in our office after 60 days.

I understand that I am ultimately responsible for payment of the services rendered to my dependents or myself.

X_____ **X**_____

Signed by Patient or Guarantor Date