



# Snell Prosthetic and Orthotic Laboratory

## PATIENT INFORMATION

ID \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Work (\_\_\_\_) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Referral Source \_\_\_\_\_  
 Referring Physician \_\_\_\_\_  
 Primary Physician \_\_\_\_\_  
 Specialist \_\_\_\_\_  
 Location \_\_\_\_\_  
 Patient E-mail \_\_\_\_\_

Notes:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Sex \_\_\_\_ M \_\_\_\_ F  
 Social Security # \_\_\_\_\_  
 Account Type \_\_\_\_\_  
 Account Status \_\_\_\_\_  
 Tax Type \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Is this work related? \_\_\_\_ Y \_\_\_\_ N  
 Date of Injury \_\_\_\_\_

### PRIMARY INSURANCE

Insurance Name \_\_\_\_\_  
 ID \_\_\_\_\_  
 Group Name \_\_\_\_\_  
 Group # \_\_\_\_\_ Pay % \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber Birthdate \_\_\_\_\_  
 Relationship \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Name \_\_\_\_\_  
 ID \_\_\_\_\_  
 Group Name \_\_\_\_\_  
 Group # \_\_\_\_\_ Pay % \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber Birthdate \_\_\_\_\_  
 Relationship \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Work (\_\_\_\_) \_\_\_\_\_

### EMERGENCY INFORMATION

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Work (\_\_\_\_) \_\_\_\_\_  
 Contact \_\_\_\_\_

I hereby request and authorize my insurance company and/or companies to pay directly to Snell Prosthetic and Orthotic Laboratory any proceeds payable under the terms of my policy and/or policies. This is an irrevocable assignment and I understand and agree any unpaid balance not covered by this policy is my obligation and will be paid by me. I also give my consent to Snell Prosthetic and Orthotic Laboratory to release and obtain information pertaining to my condition for treatment, payment, and operations effective on the date below. I understand that I have the right to revoke this consent in writing to the Privacy Officer.  
**\*Medicare Beneficiary: I have been notified and I am aware of Medicare Supplier Standards.**

Date \_\_\_\_\_ Signed \_\_\_\_\_