The Anaplastology Clinic

www.prostheticRx.com

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Durham, NC 27705

T: 919.383.1205
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New Patient Form

DATE:	/ /		Patient #								

Patient Information

Last Name		First		Middle
Address				Unit #
City		State		Zip
Phone #'s	Home ( )	Work ( )		Cell ( )
Email				
Date of Birth / /	Age	Sex: (circle one) M F		Marital Status

Emergency Contact Name

Name			Relationship
Phone #'s	Home ( )	Work ( )	Cell ( )

Responsible Party (If different then above)

Last Name		First	Middle
Address			Unit #
City		State	Zip
Phone #'s	Home ( )	Work ( )	Cell ( )
Date of Birth / /		Relationship	
Employer		Email	

Primary Insurance

Insurance Company		Phone ( )
Subscriber	DOB / /	Relationship
Policy#	Group#	Effective Date / /
Employer		Phone ( )

Secondary Insurance

Insurance Company		Phone ( )
Subscriber	DOB / /	Relationship
Policy#	Group#	Effective Date / /
Employer		Phone ( )

Referring Physician

Name	Clinic / Hospital
Address	Phone ( )

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize *The Anaplastology Clinic* to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

(Information pertains to *Medicare Patient Only)*
I request that payment of authorized Medicare benefits be made either to me or on my behalf to *The Anaplastology Clinic* for any services provided to me by *The Anaplastology Clinic*. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ **Date** _____