Anew Life Prosthetics and Orthotics

6438 Woodward Avenue, Detroit, MI 48202-3216 / Phone 313-870-9610 Fax 313-870-9620

Patient Registration

Mr/Mrs/Ms/Miss _____ **Date of Birth:** _____

Address _____ **Male** _____ **Female** _____

City, State, Zip _____ **SSN:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____ **Preferred method of contact: email/phone/text**

How were you referred to us? _____ **Cel phone provider:** _____

Emergency Contact:

Name: _____ **Relation:** _____ **Phone:** _____

Was your injury work or accident related? If so, give accident date, name and phone number of adjuster w/claim #

Are you any of the following: diabetic / in hospice care / resident of nursing home? **Yes____** No____

Marital Information: **Single** _____ **Married** _____ **Divorced** _____ **Widowed** _____

Referring Physician name and phone: _____

Primary Care Physician name and phone: _____

Insurance Information:

Primary Insurance: _____

Phone/fax: _____

Member ID/claim#: _____

Secondary Insurance: _____

Phone/fax: _____

Member/claim# _____

Please provide copy of driver license, insurance card and credit card

I authorize the release of all medical information to my insurance company or doctor when requested.

I understand/agree that regardless of my insurance status, I am ultimately responsible for balance of my account for any services provided by Anew Life Prosthetics and Orthotics, LLC and/or any other collections or statement fees.

I understand that payment is expected at the time of services unless other arrangements have been made.

I give permission for Anew Life Prosthetics and Orthotics, LLC to contact me about any matters regarding my care, insurance or remuneration. I have received a copy of DMEPOS Supplier Standards, if I am a Medicare patient. I certify this information is true, accurate and complete. I will notify Anew Life Prosthetics and Orthotics, LLC of any changes in my status regarding the above information.

Signature: _____ **Date:** _____

Self, parent/guardian if minor

If patient is physically or mentally unable to sign please provide the following:

Representative Relationship: _____

Representative Name (Print): _____

Representative Address: _____

Representative Phone: _____

Name on credit card or bank account: _____

Credit Card/Care Credit#: _____

Bank account name, number _____ **/ Routing #**_____

I agree ☐

We would like to send automated text and voice messages to the mobile phone number and email you have provided. These messages will be about your scheduled appointments. By checking the box above, you agree to receive these types of messages. Consent is not a condition for or any purchase, and you can revoke your consent at any time by informing our office. Standard message and data rates may apply. You agree to notify us promptly if your mobile phone number or email address changes. This will ensure that you, and not someone else, receives messages intended for you.

Revised 12/20/2019