Prosthetic Care Facility
of Virginia

PATIENT REGISTRATION FORM

Date:_____/_______/_______

PLEASE PRINT

Section 1 – Patient Information

Patient Name: (Last, First, Middle Initial)____

SSN:______________

DOB: ____/____/____ Age:___ Sex: M / F   Marital Status: S ☐ M ☐ W☐ D☐

Height: ______ Weight:______

US Citizen Y/N   Permanent Resident Y/N - Resident Alien #......................................

Referring Physician: ____ Diagnosis _________________

Home Address (where you are living now)__________________________________APT #:_____

City:_____________ State:____ Zip:________ Hm#:(____)_________Mobile#:(____)_________

Email:_________________________________

Patient's Employer:______ _____________________________________Phone#:(____)_______

Employer's Address:____

City:____State:__________Zip:__________________

Referring Physician _______________________________________ City_________________State______

Telephone_________________________

Section 2 –Spouse / Parent / Guardian / Responsible Party

Name(Last,First,MI):____SSN:________________________

DOB:___/____/___Age:___ Home #: (____)______________________Mobile #: (____)______________

Work #: (____)_____________

Relationship to Patient: Spouse/Parent/Guardian/Other(Explain):__________________________

Home Address: ________________________________APT #: _________City:________________

State: _____Zip:__________Employer:____________Employers'sAddress:_________________

________________Ste. #_________City: __________________State: _______Zip:_________

Section 3 – Emergency contact

Name (Last, First, MI):____

Home #:(___)_________ Work #:(___)__________ Relationship: ____________

Address: _____________________________City:_________________ State:____ Zip:____

Section 4 – Person(s) authorized to discuss information regarding your care.

Name: ____________________________________ Relation to patient: _________________

Phone #: (___)____________

Do we have permission to leave a message on an answering machine? ___________

Section 5 – Insurance Information

Primary Insurance: ____

Policyholder: ______________________________________Policyholder DOB:____/____/_____

Policyholder SSN: _____________________________________Group #: _________________

ID #: _________________Case Manager: ____

Tel #: _(_____)________Patient's Relationship to Policyholder: ________________

Secondary Insurance: ____

Policyholder:___________________________________ __ Policyholder DOB: ____/____/____

Policyholder SSN: _____________________________________Group #: __________________

ID #:__________________ Case Mgr: ____

Tel #: (____)_______Patient's Relationship to Policyholder: ____________________________

OTHER INSURANCE

Worker's Comp? Y/N *Is this due to an Auto/Home accident? Y/N* *Date of Injury:____/____/____*

Location of accident: ________________________*Ins:* ______________________________________

*Policy #:*__________________

Case Manager: __________________Tel #:_____________ Address: ___________________________

City:______________ State: ____Zip: _____________ Fax#:_(___)___

Signature__________________________**Name**____________________________**Date**___/___/_____

Divorced Parents: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all charges.

I hereby request Prosthetic Care Facility to provide any prosthetic/orthotic services necessary, per my physician's prescription.

Patient's Signature: ____ Date: ___/___/____

Responsible Party: ____Date: ___/___/____

Thank you for taking the time to fill out this form