ADVANCED PROSTHETICS & ORTHOTICS

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? YES_____ NO _____

PATIENT INFORMATION:

Male/ Hombre ☐ **Female/Mujeres** ☐	**SSN/Numero de seguro social:**	**DATE OF BIRTH/ Fecha de nacimmiento**
FIRST NAME/ Primera Nombre	MIDDLE NAME	LAST NAME / APELLIDO
ADDRESS / Direción:	CITY, STATE, ZIP: Ciudad, Estado, código postal	
HOME PH / Teléfono casa:	CELL # / Teléfono cellulares:	WORK PHONE# / Teléfono trabajo:
EMPLOYER / Empleador:	EMPLOYMENT ADDRESS / El empleo de direcciones:	

EMPLOYED ☐ STUDENT ☐ RETIRED ☐ OTHER ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ CHILD ☐

HEIGHT:	WEIGHT:	**ANY KNOWN ALLERGIES:** **HEPATITIS** ☐ **HIV** ☐
DIABETIC? YES ☐ **NO** ☐	**TREATING DIABETIC PHYSICIAN:**	**DIABETIC DOCTOR'S PHONE NUMBER:**

PARENT/GUARDIAN/AUTHORIZED REPRESENTAIVE OR ALTERNATE CONTACT PERSON
NAME: **PHONE #:**

PRIMARY INSURANCE (Seguro primario)

INSURANCE NAME / seguro de nombre:	MEMBER# (numero miembro)
INSURED NAME:	**INSURED DOB & SSN#**
AUTHORIZATION INFO:	

SECONDARY INSURANCE (Seguro secundario)

INSURANCE NAME / seguro de nombre:	MEMBER# (numero miembro)
INSURED NAME:	**INSURED DOB & SSN#**
AUTHORIZATION INFO:	

WORKER'S COMPENSATION / THIRD PARTY ACCIDENT INFORMATION

ACCIDENT YES ☐ NO ☐ WORK RELATED YES ☐ NO ☐	DATE OF INJURY	CLAIM#
ATTORNEY:	WORKER'S COMP. ADJUSTER NAME:	PHONE#:

I hereby direct that my primary, medi-gap and or secondary health insurance provider(s) pay Advanced Prosthetics and Orthotics directly for services rendered and/or goods provided. I understand that I am financially responsible for any unpaid balance and any unpaid co-pays or deductibles. I hereby authorize any physician, chiropractor, surgeon practitioner, or other person, attorney, and hospital, including Veterans Administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other any and all medical records or other information including benefits paid or payable, including information relative to diagnosis and or treatment. A Photostat of this original shall be as valid as the original.

Patient Signature _____ Date _____

☐ **2650 N. Tenaya Way, Suite 210, Las Vegas, NV 89128 Phone: 702-256-5265 Fax: 702-256-5205**
■ **1505 Wigwam Parkway Suite# 345, Henderson, NV 89074 Phone: 702-260-0467 Fax: 702-260-8104**
☐ **2281 E. Postal road #5-6, Pahrump, NV 89048 Phone: 775-751-2030 Fax: 775-751-5370**

Firma del paciente	Feche

Acknowledgement of Notice of Privacy Practices (HIPAA)

I certify that I have received a copy of Advanced Prosthetics & Orthotics Notice of Privacy Practices. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Advanced Prosthetics & Orthotics health care operations. The Notice of Privacy Practices also describes my rights and Advanced Prosthetics & Orthotics duties with respect my protected health information. The Notice of Privacy Practices is posted in the waiting room.

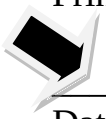
Advanced Prosthetics & Orthotics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____

Patient Signature (Parent or Designated representative)
Letrero con su nombre / Firma

_____

Printed Name of above **(escriba el nombre)**



_____

Date **(feche)**

_____

Relationship to Patient (If signed by other than patient)
Relación con el paciente