

ADVANCED PROSTHETICS & ORTHOTICS

**ARE YOU CURRENTLY IN A SKILLED
NURSING FACILITY? YES _____ NO _____**

PATIENT INFORMATION:

Male/Hombre <input type="checkbox"/> Female/Mujeres <input type="checkbox"/>		SSN/Numero de seguro social:	DATE OF BIRTH/ Fecha de nacimiento
FIRST NAME/ Primer Nombre		MIDDLE NAME	LAST NAME / APELLIDO
ADDRESS / Dirección:		CITY, STATE, ZIP: Ciudad, Estado, código postal	
HOME PH / Teléfono casa:	CELL # / Teléfono celulares:	WORK PHONE# / Teléfono trabajo:	
EMPLOYER / Empleador:		EMPLOYMENT ADDRESS / direcciones de empleo:	
EMPLOYED <input type="checkbox"/> STUDENT <input type="checkbox"/> RETIRED <input type="checkbox"/> OTHER <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> CHILD <input type="checkbox"/>			
HEIGHT:	WEIGHT:	ANY KNOWN ALLERGIES:	HEPATITIS <input type="checkbox"/> HIV <input type="checkbox"/>
DIABETIC? YES <input type="checkbox"/> NO <input type="checkbox"/>	TREATING DIABETIC PHYSICIAN:		DIABETIC DOCTOR'S PHONE NUMBER:
PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE OR ALTERNATE CONTACT PERSON			
NAME:		PHONE #:	

PRIMARY INSURANCE (Seguro primario)

INSURANCE NAME / Aseguranza primaria:	MEMBER# (numero miembro)
INSURED NAME: (Nombre De La Persona Con La Aseguranza)	INSURED DOB & SSN# (Fecha De Nacimiento / Numero De Seguro Social)
AUTHORIZATION INFO:	

SECONDARY INSURANCE (Seguro secundario)

INSURANCE NAME / Aseguranza secundaria:	MEMBER# (numero miembro)
INSURED NAME:	INSURED DOB & SSN#
AUTHORIZATION INFO:	

WORKER'S COMPENSATION / THIRD PARY ACCIDENT INFORMATION

ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	WORK RELATED YES <input type="checkbox"/> NO <input type="checkbox"/>	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 _____
Firma del paciente

Date _____
Fecha

- 7455 W. Washington Ave, Suite 215, 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

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)
Del paciente/guardian

Printed Name of above (Por favor escriba nombre)



Date (fecha)

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