ABILITY PROSTHETIC SYSTEMS, INC.

Patient Information Sheet

Last Name_____ First Name _____MI_____

Address_____ City_____State_____ Zip_____

Date of Birth ____/____/____ Social Security #: _____/____/_____ Sex: Male☐ Female ☐

Home Phone _____ Cell _____ Work _____

Employer: _____ Email: _____

SPOUSE INFORMATION

NAME:_____

PHONE:_____

RESPONSIBLE PARTY

SELF ☐

PARENT/GUARDIAN ☐

OTHER _____ ☐

EMERGENCY CONTACT

(Other Than Spouse)

NAME_____

Relationship:

- ☐**Son**
- ☐**Daughter**
- ☐**Neighbor**
- ☐**Friend**
- ☐**Other** _____

Phone:_____

Date of Amputation: _____/_____/_____

Side: Right ☐ Left ☐ Level_____

Which of the Following Is Your Condition

Related to:

- ☐ Illness
- ☐ Accident
- ☐ Industrial
- ☐ Other

Please explain _____

_____

Referring Doctor _____

Phone #: _____

UPIN #: _____ NPI #: _____

Primary Doctor _____

Phone #: _____

UPIN #: _____ NPI #: _____

To the best of my knowledge, the above information is correct** I will notify Ability Prosthetic Systems, Inc. If any of my personal information changes. **

**NOTE – At the time of your scheduled visit you will be required to bring with you your drivers license, any insurance cards if you have insurance and your social security card. Originals of these documents will only be accepted, please no photocopies due to federal regulations and the new red flag identity theft law.

Patient Signature_____ Date_____

Please Fill Out Other Side

ABILITY PROSTHETIC SYSTEMS, INC.

Authorization For Payment

Patient Name: _____ Social Security #: _____/_____/_____

Primary Payor: _____ Policy Number:_____

Secondary Payor:_____ Policy Number:_____

I request that payment of benefits be made on my behalf directly to Ability Prosthetic Systems, at 750 East 100 South, Salt Lake City, Utah, 84102 for any and all services provided me by this agency.

I authorize any holder of medical information about me to release information necessary for Medicare/Medicaid/Private Health Insurance Plan or any other applicable third party payor and it's agents any information needed to determine these benefits.

Signed:_____ Date:_____

Printed Name:_____

Witness: (if applicable:

_____
Signature

_____
Printed Name

_____
Address

_____
City State Zip

If patient is unable to sign, a legal guardian, representative payee, relative, or friend may sign on their behalf.

_____
Signature

_____
Printed Name

_____
Address

_____
City State Zip

Relationship to patient: _____

Reason patient unable to sign: _____
_____
_____