



**Patient Information**

Mr. Mrs. Miss \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name First Name M.I.  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email Address \_\_\_\_\_

Social Security # \_\_\_\_\_  
Drivers License # \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Marital Status: Married Single Divorced Widowed Minor  
Employer \_\_\_\_\_ Employer's Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer's address (Street, City, State, Zip) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Emergency Contact Address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
Physician Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Hip BK AK BE AE RIGHT LEFT  
Reason for Amputation \_\_\_\_\_ Amputation Date \_\_\_\_\_  
Is Injury Related to: Work Auto Other Accident Non-accident Allergies \_\_\_\_\_

If "Work," answer the following: Employer at time of injury \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Workers' Comp. Insurance Name & Address \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Claim # \_\_\_\_\_ Adjustor \_\_\_\_\_

**Assignment of Benefits / Authority for Release of Information**

I request that payment of authorized Medicare, Medicaid, or private Insurance benefits be made to **Strobel & Associates Prosthetics** for any covered services furnished to me by **Strobel & Associates Prosthetics**. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

\_\_\_\_\_  
Patient's Signature (or Parent / Guardian) \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Representative's Signature (if Patient is unable to sign) \_\_\_\_\_ Relation to Patient \_\_\_\_\_