

Hagen Orthotics & Prosthetics

306 Becker Ave SW

Willmar, MN 56201-3341

Phone: (320) 222-3260

Fax: (320) 222-3262

PATIENT INFORMATION

NAME _____

BIRTH DATE _____ AGE _____

SSN# _____

Male _____ Female _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

HOME PHONE _____

WORK/CELL PHONE _____

EMPLOYER _____

REFERRING PHYSICIAN _____

PRIMARY PHYSICIAN _____

BILLING / RESPONSIBLE PARTY

_____ IF SAME AS ABOVE-SKIP THIS SECTION

NAME _____

SSN# _____

DOB _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____

HOME PHONE _____

WORK/CELL PHONE _____

RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE INFORMATION

COMPANY _____

ID# _____ GROUP# _____

POLICY HOLDER _____

DOB _____ SSN _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE

COMPANY _____

ID# _____ GROUP# _____

POLICY HOLDER _____

DOB _____ SSN _____

RELATIONSHIP TO PATIENT _____

WORK COMP INJURY _____ or AUTO INJURY _____

DATE OF ACCIDENT _____

INSURANCE COMPANY _____

CLAIM# _____

CONTACT _____

PLEASE SIGN & DATE

I assign to Hagen O&P, permission to bill my insurance company and release information pertaining to claim submittal.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Have you received or replaced your present Orthosis/Prosthesis within the last five yrs. Yes _____ No _____

Are you allergic to any materials? Yes: _____ No: _____

I acknowledge that I have received.

1) Medicare Supplier Standards

2) Notice of Privacy Practices

3) Patient Bill of Rights

SIGNATURE _____

TODAY'S DATE _____