REGISTRATION FORM

Bay Orthopedic & Rehabilitation Supply Company, Inc.
Corporate Headquarters: 616 East Jericho Turnpike,
Huntington Station, NY 11746
Telephone #: 631-271-0825 Fax #: 631-271-136

PATIENT DEMOGRAPHICS

FIRST NAME: ________________________ LAST NAME: ________________________

DATE OF BIRTH: ____________ AGE:________ SEX: ___ HEIGHT: ______ WEIGHT: ______

SOCIAL SECURITY # OF PATIENT ***(REQUIRED TO VERIFY INSURANCE)***: ________________________

HOME ADDRESS: ________________________

CITY: ________________________ STATE: ____________ ZIP CODE: ________

HOME PHONE #: ________________________ CELL PHONE #: ________________________

EMAIL ADDRESS: ________________________

OCCUPATION & WORK PHONE#:________________________

IF PATIENT IS UNDER 18 YEARS OLD THE FOLLOWING IS REQUIRED

NAME OF AUTHORIZED REPRESENTATIVE:________________________

DESCRIPTION OF AUTHORIZED REPRESENTATIVE'S RELATIONSHIP:________________________

AUTHORIZED REPRESENTATIVE'S SOCIAL SECURITY #: ________________________

EMERGENCY CONTACT (TO BE CONTACTED IN THE EVENT OF EMERGENCY OR IF WE CAN NOT REACH THE PATIENT)

FULL NAME:________________________

RELATIONSHIP TO PATIENT:________________________ TELEPHONE#:________________________

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE: ________________________ ID#: ________________________

SECONDARY INSURANCE: ________________________ ID#: ________________________

MEMBER'S NAME:________________________ MEMBERS SOCIAL SECURITY #: ____________

MEMBER'S DATE OF BIRTH:________________ MEMBER'S RELATIONSHIP TO PATIENT: ____________

MEDICAL HISTORY

Have you been to Bay Orthopedic & Rehab. Supply Co. Inc. before? __________ If yes, when?________________________________

What is the name of your referring doctor? ____

Are you Diabetic? ______________ Do you smoke?_________ Do you drink? __________

Do you experience edema or swelling in any body parts? __________ If yes, where? ______________________________

Have you worn a device for this condition within the last 5 years? ___________

Are you actively or have you recently been in a rehab center, nursing home or hospital? ____________________________

If yes, where? _________________________ How long? ___________________ Why? ______________________________

Are you allergic to Latex, Neoprene, Fiber Glass or any other materials etc.? __________ If yes, which? _________________________

Other medical history you wish to disclose:____

PATIENT ACKNOWLEDGEMENTS

- I certify that the information I provided is true and complete, and authorize the release of medical or other information necessary to process this claim to any insurance company/attorney involved.
- I permit a photocopy of this assignment/authorization to be used in place of the original. I authorize payments directly to Bay Orthopedic & Rehab. Supply Co. Inc. if assignments have been accepted.
- I permit full use of photographs, videos for medical review, examinations, treatment/evaluations, etc.
- I am aware that copies of this form as well as HIPPA Privacy Practices and Medicare Supplier Standards are posted in the office and on the website, and copies are available.
- I understand that I am fully responsible to, Bay Orthopedic & Rehab. Supply Co. Inc., for any balance not covered by my insurance company and that I am responsible to pay these balances within 30 days or I will incur a surcharge of 1 ½ % per month in addition to any collection/attorney fees incurred.
- I authorize Bay Orthopedic & Rehab. Supply Co. Inc. to use the phrase SIGNATURE ON FILE on any claims or credit cards slips in order to process or pay for services rendered. My signature remains effective until it has been removed by me in writing.
- This assignment of benefits and these payment rules has been explained to my full satisfaction.

Signed by: ____ Date:_________________________

Policy Holder/Authorized Person

Print Name:__________________________________ Patient ID#:____________ Invoice/Order#:________________