

Great Plains Orthotics & Prosthetics, Inc.

Ames Cedar Rapids Davenport Des Moines (2 locations) Fort Dodge

Patient's Name: _____
Home Address: _____
Mailing Address (if different): _____
City: _____ State: _____ Zip: _____
Telephone: (____) _____ Date of Birth: _____ Sex: M / F
Social Security Number: _____ Height: _____ Weight: _____
Employer: _____ Phone #: (____) _____
May we contact you at work? Yes _____ No _____
Referring Physician: _____ Phone #: (____) _____

If Diabetic Physician overseeing care: _____ Phone #: (____) _____

*Have you received the same or similar device within the past 5-7 years: Y / N (please circle one)
Whom may we thank for referring you to our office? _____

Whom may we contact between 8:00a.m. & 5:00p.m. to set appointments, if different than yourself?
Contact Name _____ Phone #: (____) _____ Relationship: _____

Please provide us with the following information regarding your insurance coverage, check the primary insurance. (Complete only those areas that apply) Please have your insurance cards ready, we would like to take a photo copy of them for our records.

Insurance Company _____
Address _____ Phone#(____) _____
City _____ State _____ Zip _____
Subscriber Name _____ ID# _____ Plan _____
Medicare ID#: _____
Medicaid: _____ Do you have a spenddown: Y / N
Veterans Administration _____
Worker's Compensation - Employer _____ Phone#(____) _____ Compensation
Carrier _____ Phone#(____) _____
Address _____ City _____ State _____ Zip _____
Verified with _____ Date _____ Time _____

- Do you want us to file your insurance? Yes _____ No _____
- You are responsible for full fee payment at time of delivery unless other arrangements have been agreed upon with your practitioner.
- Custom braces require a deposit at time of measurement and/or casting.
- There will be no returns on devices ordered by doctor's prescriptions.

To my knowledge all the above information is correct. I understand I am financially responsible for all charges. I also agree to make payment at time of delivery.

Signature of Responsible Party Date

I understand that by signing above I give authorization to Great Plains Orthotics & Prosthetics, Inc. to file my insurance and release any necessary information to my insurance company to determine the benefits payable.