Basin Orthotic & Prosthetic Center

623 N Sam Houston Ave   Odessa, TX 79761   Ph(432) 337-8880   FAX(432)337-8887

NEW PATIENT REGISTRATION (PLEASE PRINT)

Patient Information

Referring physician	Last Name	First Name	Middle Initial

Address	Social Security #	Driver's License #

City	State	Zip Code	Gender ☐ Male ☐ Female

Email:

Date of Birth	Age	☐ Single ☐ Divorced ☐ Married ☐ Widowed	Home Phone #	Cell Phone #

Employer	Occupation	Work Phone #

Employer Address	City	State	Zip Code

Emergency Contact (Name, Relationship)	Emergency Contact #

Responsible Party Information (if different than above)

Last Name	First Name	Middle Initial	Social Security #

Address	Date of Birth

City	State	Zip Code	Home Phone #

Employer	Employer Address	City	State	Zip

Relationship to Patient	Work Phone #	Cell Phone #	Best Daytime Number ☐ Work ☐ Home ☐ Cell

Primary Insurance Information

Name of Insurance Company	Policy ID Number	Group Number	Insured Social Security #

Insured Name	Insured Date of Birth	Relationship To Patient

Secondary Insurance Information

Name of Insurance Company	Policy ID Number	Group Number	Insured Social Security #

Insured Name	Insured Date of Birth	Relationship To Patient

Authorization, Consent and Assignment of Benefits

I hereby consent to care with Basin Orthotic & Prosthetic Center to include: Evaluation, Diagnostic, Consultation and Treatment for prescribed orthotic and/or prosthetic care. I authorize my insurance benefits to be paid directly to Basin Orthotic & Prosthetic Center and understand that I am financially responsible for all non-covered services. I agree to the release of any protected health information regarding evaluation and treatment for orthotic and/or prosthetic devices for the purpose of processing this claim. I request that payment of authorized Medicare benefits be made on my behalf to Basin Orthotic & Prosthetic Center for any services provided to me by their employees and/or facility. This authorization and assignment is permanent and will remain on file and be used on future claims. I may revoke it at any time by written notice. I acknowledge that I have received a copy of the Notice of Privacy Practices for Basin Orthotic & Prosthetic Center.

Signature ______________________________ Date ______________

Responsible Party Name (Print) ______________________________ Relationship to Patient ______________

Responsible Party Signature ______________________________ Date ______________