Southern California Prosthetics, Inc.
12 Goodyear, Suite 130
Irvine, CA 92618
Telephone: 949-892-5338
Fax: (949) 419-6478

Patient Information

Last Name: ______________________ First Name: ______________________ Middle Initial: ______

Street Address: ______________________ City, State, Zip: ______________________

Home Phone: ______________ Work Phone: ______________ Alternate Phone: ______________

SS#______________DOB:__________ Gender:___M___F Ht:_____ Wt:_____ Diagnosis/Type of Amputation: ______________

Driver's License No. ______________ Marital Status ________ E-Mail Address ______________

Emergency Contact ______________________ Medical Concerns ______________________

Date of Amputation (if applies) ______________ Affected Side: _______ Left _______ Right _______ Bilateral _______ N/A

How did you hear about us? _______ Inmotion Ad _______ Website _______ Referral (Referred by ______________) _______ Other

Physician Information

Referring Physician Name: ______________________ UPIN: __________ Medipass #: __________

Street Address: ______________________ City, State, Zip: ______________________

Phone: ______________________ Fax: ______________________

Primary Physician Name: ______________________ UPIN: __________ Medipass #: __________

Street Address: ______________________ City, State, Zip: ______________________

Phone: ______________________ Fax: ______________________

Insurance Information

Primary Insurance: ______________________ ID#: ______________ Group #: ______________

Insured's Name: ______________________ Insured's DOB: __________ Relationship to Insured: __________

Street Address: ______________________ City, State, Zip: ______________________

Phone: ____

Secondary Insurance: ______________________ ID#: ______________ Group #: ______________

Insured's Name: ______________________ Insured's DOB: __________ Relationship to Insured: __________

Street Address: ______________________ City, State, Zip: ______________________

Phone: ____

Guarantors Name (if patient is a minor):______________________ Guarantors SS# ______________

If Workman's Comp: Claim Number __________ Date of Accident: __________ Adjuster Name __________ Adjuster Phone: __________

Benefits, Medical Information Release Authorization and Acknowledgment of Financial Responsibility:
I request my insurance benefits, if any, be paid directly to Southern California Prosthetics, Inc. I authorize the release of any information necessary to provide services or process claims. I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or not-covered. In the event my insurance carrier does not except Assignment of Benefits or if payments are made directly to me or my representative, I will endorse such payments to SCP. I agree to notify Southern California Prosthetics, Inc. immediately of any change in insurance coverage or status.

I understand that I have the right to request and receive a **Notice of Privacy Practices from SCP.**

______________________________________ ______________

Patient Signature Date

______________________________________ ______________

Responsible Party Signature: Relationship Date