HIGHLAND
ORTHOPEDIC SUPPLY

Toll Free 800-583-3771
www.highlandorthopedicsupply.com

PATIENT INFORMATION FORM

Name:			Date of Birth	SS #	☐ Male ☐ Female
Address			Home Phone ( )		
City	State	ZIP	Work Phone ( )		

TO BE COMPLETED BY PATIENT

Check what applies: ☐ Work Injury ☐ Auto Accident ☐ Other _____ Date Of Injury: MM/DD/YY _____ /_____ /_____	Attorney Information	Attorney Phone Number ( )
	Workers Comp. Information	Workers Comp. Phone Number ( )
	Employer Name	Employer Phone Number ( )

Note: PLEASE INCLUDE COPY OF Health Insurance Card!

Primary Insurance:	Policy #:
Patients Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	Primary Insurance Phone Number: ( )
Primary Insured's Name	Insurance Address
Secondary Insurance:	Policy #:
Patients Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	Secondary Insurance Phone Number: ( )
Prescribing Physician:	Physician Phone Number: ( )
Clinic/PT:	Clinic Phone Number: ( )

Documentation Provided Please Check	Manufacturer Documentation	Warranty	Serial #	Product	Supplier Standards	Notice of Privacy Practices

I authorize the release of any medical information to process my claim concerning the medical equipment or supplies which are being supplied to me by Highland Orthopedic Supply, Inc. and I permit a copy of this authorization to be as valid as the original.

Patients Signature _____ Date : ____/____/____

Insured's Signature (if differed from patient)

_____ Date: ____/____/____