OERTEL
ORTHOPEDICS, INC.
2095 Route 22 West Union, NJ 07083 Tel (908) 688-1818

Patient Information

Patient Name_______________________________ DOB___________ Social Security #_____________
Address__________________________________ City____________ State__________ Zip_________
Drivers License #_______________________ Male___ Female___ Height______ Weight _________
Phone Number ____________________________ Alternate phone number______________________
Marital Status: Married__ Widowed__ Divorced__ Separated__ Single__ Other__
Employed Yes__ No__ Retired Yes__ No__ In school Yes__ No__
Employer ____
Email Address _________________________
May we send you electronic email? Yes__ No__ May we leave a voice mail? Yes__ No__

Insurance

Type of Claim WC__ PIP__ Date of Accident _______ Other ______
Primary Insurance____________________ ID#_____________________ Grp #__________________
Secondary Insurance__________________ ID#_____________________ Grp # _________________
Primary Policy holder/ Guarantor ______________________________ DOB ____________
Patient Relationship to Guarantor Self__ Spouse__ Child__ Other__
Guarantor Address ______________________________ City ___________ State _______ Zip ______
Phone Number _____________________
Power of Attorney Yes__ No__

Medical History

Are you a diabetic Yes__ No __
Treating Physician Name ________________________________ Phone # _____________________
Address ____
Has the beneficiary ever received the same or similar supplies/equipment? Yes __ No __
If yes list supplies:
Date provided _______________
Is this item being replaced? Yes__ No__
Prescribing/Referring Physician Name ___________________________ Phone # _________________

Emergency Contact

Emergency Contact___________________ Tel#_________________ Relationship________________
Who do you authorize to contact Oertel Orthopedics and obtain medical information about you?
Name_____________________________ Phone# ________________ Relationship ____________
Name_____________________________ Phone# ________________ Relationship ____________
How did you hear about us? ____

I understand and agree to pay, all fees not covered by my insurance company(s) in a timely manner. I also understand that late fees at a rate of 1.5% month will be added to my balance in accordance with NJAC 39:6a-5c for any unpaid balances that are over 60 days old. In addition, if my delinquent account is sent to a collection agency a 20% collection fee will be added. I also agree to release any medical records necessary to process this claim. By the terms of this agreement I verify that all the above information is correct and authorize Oertel Orthopedics, Inc. to order, fabricate, and/or make effective repairs, for my medical device(s).

Patient/Responsible Guardian Signature:_______________________________________ Date:________________