Phone: (919) 267-5284
Fax: (888) 635-6138
www.delbiancopo.com
Apex and Raleigh Clinics

NAME AND CONTACT INFORMATION

Patient Name ___________________________________Preferred Name ______________________________

Date of Birth (month-day-year) ________________ Social Security Number__________________________

Address ____City_______________State_______ Zip_________

Phone (Home) ________________________ (Cell) _______________________ (Other) __________________

Email Address: __________________________________ Appointment Reminder: ☐Call ☐Text

By checking this box to receive text messages you agree to receive recurring messages from Del Bianco Enterprises, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

Occupation: ______________________ Employer: ______________________Phone: ____________________

Best Way to Contact: Email / Cell # / Home # / Work# / Other _______________________________________

Responsible Party/Guardian Name (if applicable) ____

Referred by: Doctor / Website / Friend / Therapist / Other ____

PERSONAL INFORMATION AND MEDICAL HISTORY

Legal Sex: M / F Preferred Pronouns: He/Him / She/Her / They/Them / Other: ________________

Age _____________ Height _____________ Weight _____________ Shoe Size _____________

Marital Status: Single / Married / Divorced / Separated / Widow

Latex Allergy: Y / N Any other material allergies? Describe: ___________________________________

Mark the following conditions that apply now or in the past:

_____ Diabetes Type I	_____ Hospitalization	_____Surgeries
_____ Diabetes Type II	_____ Infectious Disease	_____Tuberculosis
_____ Neuropathy	_____ Loss of Balance	_____Heart Condition –Describe__________________
_____ Hepatitis	_____ MRSA / ORSA	_____ HIV

If diabetic, who is the physician who treats your diabetes? ____

Have you received any prosthesis or orthosis (brace) in the last 5 years? If so, please describe the device and when and where you received the item:

____

____

What goals or expectations do you have for your new prosthesis or orthosis (brace):

____

____

INSURANCE INFORMATION

Please give your insurance cards to the receptionist so a copy can be made.

Is the patient covered by insurance: Y / N What is the primary insurance company? ______________

Does a secondary insurance apply: Y / N What is the secondary insurance company?

What is the patient's relation to the subscriber? Self / Spouse / Child

Subscribers Name: ___________________________________ Date of Birth ________________

Is the item you are here to receive a worker's compensation claim? Y / N

If yes, please provide claim # and carrier information:

____

REFUND INFORMATION

Once your insurance has processed your claim, who should a refund check be issued to in the case of an overpayment?

Name that should appear on check: ____

Address check should be mailed to: ____

EMERGENCY CONTACT

In case of an emergency please provide the name and phone number of an emergency contact person:

Name: ___________________________________ Phone: _____________________________

SIGNATURE SECTION

The above information is true to the best of my knowledge. I authorize and assign my Medicare and/or other insurance benefits to be paid directly to Del Bianco P&O. I authorize Del Bianco P&O and its affiliates to release any part of my medical record and related information required to process claims. In addition, I also authorize Del Bianco P&O to obtain any medical records from my doctor, therapist, or other healthcare/rehab center that may be needed to properly process/appeal my claim. I understand that Del Bianco P&O will file a claim with my insurance(s) on my behalf, but that I am ultimately financially responsible for the entire bill. I understand without sufficient verification of current medical insurance coverage, payment is due at time of service/delivery. By signing below, I am also acknowledging acceptance of Del Bianco P&O HIPAA Notice of Privacy Practices, warranty/refund information, Medicare supplier standards, mission statement, patient rights and responsibilities, and financial policy. These documents are provided for your review when you fill out this registration form. They are also available to you upon request. Please ask if you have any questions about the statements above.

Patient Signature ____ Date_______________________

Legal Guardian____Date_______________________

Relationship of Guardian to Patient ___________________________________