GREAT LAKES ORTHOPEDIC LABS, INC.
2362 Genesee Street, Cheektowaga, NY 14225
Tel. No. (716) 893-4116

GREAT LAKES ORTHOPEDIC LABS, INC.
219 Bryant Street, Buffalo, NY 14222
Tel No. (716) 878-7307

PATIENT INFORMATION

Patient's Name ______________________________ Sex – M ____ F ____

Patient's Social Security No. ______________________ Date of Birth ____________

Patient's Street Address ____

City, State and Zip Code ___________________________ County ____________

Home Telephone No. ________________ Cell Phone No. ________________

Diagnosis ______________________ Prescribing Doctor ________________

Physical Therapist ________________

RESPONSIBLE PARTIES

Father or Guardian ____

Date of Birth ________________ Social Security No. ________________

Address: ____

Home Telephone No. ________________ Work No.________________

Employer and Address____

Mother or Guardian ____

Date of Birth ________________ Social Security No. ________________

Address: ____

Home Telephone No. ________________ Work No. ________________

Employer and Address____

INSURANCE INFORMATION

PRIMARY INSURANCE (Include Subscriber's Name, Identification No. and Group No.)

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SECONDARY INSURANCE (Include Subscriber's Name, Identification No. and Group No.)

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IF MEDICAID – Identification # ____________________Sequence # ______________

(Two digit number located at lower right hand corner of card)

(OVER)

Insured's Name ____ (Complete below if different than above)

Date of Birth __________________ Social Security No. ____________________________

Address: ____

Home Telephone No. _____________________ Work No. _________________________

Place of Employment ____

ADDITIONAL FUNDING AVAILABLE

Physically Handicapped Children's Program (or State Aid) Do you wish to apply to this program? Please speak with Office Assistant if you are unfamiliar with this Program. Yes___ No ____

Early Intervention Program (For children age 3 years or younger) Is your child enrolled in the Early Intervention Program? Yes _______ No ________

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ASSIGNMENT OF BENEFITS - I hereby authorize the insurance companies listed above to make payment of benefits directly to Great Lakes Orthopedic Labs, for services rendered by them. I also authorize the release of any medical information by Great Lakes to process any claims.

FINANCIAL AGREEMENT - I hereby agree that in consideration of the services rendered, I shall pay the account of Great Lakes Orthopedic Labs in accordance with their charges for services rendered. I also understand that for any unpaid balance after 30 days, a charge of 1.5% monthly will be assessed on the account. I also agree that if the account becomes delinquent and thereby requires the services of an attorney for collection, I shall pay reasonable collection expenses and attorney's fees.

____ ____________________________

Patient's Signature or Authorized Representative **Date**